MEDICAID STATE MANAGEMENT REPORT

CALIFORNIA TITLE XIX PROGRAM

August 1978 - March 1979

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Health Care Financing Administration

Medicaid Bureau, Region IX

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
HEALTH CARE FINANCING ADMINISTRATION
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September 10, 1979

Beverlee A. Myers, Director
Department of Health Services
714 P Street, Room 1253
Sacramento, California 95814

Dear Ms. Myers:

We are hereby transmitting a copy of the Medicaid State Management Report on California's Title XIX Program. Included at the end is your response to the findings and recommendations of our assessment. As previously agreed, we have made several changes in our original text, based on factual errors which you pointed out. Such changes are noted by each relevant item in your response.

In the near future we will be discussing with you the development of a Corrective Action Plan outlining the specific steps the State will be taking to act on the recommendations, and the anticipated completion dates for these actions.

Copies of the Assessment Report and your response are being sent to our Central Office, selected Congressional Representatives, the Governor, selected members of the California Legislature, various provider and recipient groups and other interested parties.

We want to thank you for the help and cooperation of your staff in completing this review.

Sincerely yours,

Lawrence L. McDonough
Regional Medicaid Director

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REGION IX

DEPARTMENT OF HEALTH, EDUCATION & WELFARE

HEALTH CARE FINANCING ADMINISTRATION

MEDICAID BUREAU

Summary of Major
Findings and Recommendations

CALIFORNIA STATE ASSESSMENT

August, 1978 - March, 1979

CALIFORNIA STATE ASSESSMENT

SUMMARY OF MAJOR FINDINGS AND RECOMMENDATIONS

Between August, 1978 and March, 1979, Region IX conducted a management assessment of the California Medi-Cal program. The purpose was to provide an overview of the program, to identify potential problem areas and to offer recommendations for solutions and/or improvement. The method was review of existing documentation along with on-site visits by assessment teams, meeting with staff of California's Department of Health Services (DHS), the Medicaid single State agency, as well as with other associated groups such as fiscal intermediaries, county staff, provider groups and consumers.

The findings of this assessment indicate that, overall, the State is administering a very large and complicated program in an acceptable manner. However, there are problems in each of the areas reviewed which do require corrective action. The major findings and recommendations of this assessment are summarized below, and a more detailed explanation of these, as well as additional findings and recommendations, can be found in the full text.

There are several other significant problem areas on which the Regional Office and State staff are working that are not included in this report.

I. ADMINISTRATION AND MANAGEMENT

Any evaluation of Medi-Cal administration and management must take into account the tremendous size of this program - one of the two largest in the country - as well as its extremely broad scope of both eligibility and benefits. As a result, California faces many situtations which are either unique or of much greater magnitude than found elsewhere. During this assessment, in many areas no major problems were encountered, and a number of particularly effective policies and procedures were noted, including the open and receptive relationship of the Director of DHS with the Legislature, providers and consumer groups; the impact of the Medicaid Advisory Committee; and certain Field Office and County Welfare Office operations.

A. Fragmentation of Authority and Control

A major finding was the extreme fragmentation of authority and control within the Medi-Cal program, particularly involving the Department of Finance (DoF), Department of Corporations (DoC), Department of General Services, Department of Social Services (DSS), and many segments of DHS outside Medical Care Services, giving rise to substantial problems in coordination and uniformity of understanding among both State and county employees. In addition, the degree of control exerted by DoF appears to violate federal requirements that the requisite authority of the Medicaid single State agency, DHS, not be impaired.

Recommendations: The State should take whatever steps necessary to place day-to-day control of the Medi-Cal program solely in the hands of DHS, as required by federal regulations. It should also review the overall organization and administrative authority of the Medi-Cal agency, with consideration toward realigning functions to provide better coordination for field offices and County Welfare Office staff. The consolidation of authority for all eligibility determinations, including the medically needy, in DSS should also be explored.

B. Staffing

The cutbacks in staff allocations and the many unfilled vacancies resulting from Proposition 13 are major problems affecting all program areas and organizational units, and preventing the Medi-Cal program from functioning at acceptable levels. Failure to provide adequate resources is bringing the State in some areas to the point of being out of compliance with minimum federal requirements, which could lead to loss of federal financial participation (FFP).

Recommendation: The State should review its current allocation of resources and work toward improving the major shortage areas, such as computer programmers, audit staff, Third Party Liability recovery staff, physicians in DHS headquarters, and clerical staff and social workers in the Field Offices.

C. Transportation

Federal regulations require that States assure necessary medical transportation for recipients to and from providers. Of the three levels of transportation included under Medi-Cal, only emergency needs appear to be adequately met. Funds for regular medical transportation are considered included in cash grants, but the amount is non-specific and the grant appears inadequate for maintenance needs and transportation both. Payment for those with "recurring special needs" is left to the counties, with problems of an unreasonable limit on the amount allowed, and no funds at all available in some counties due to Proposition 13. And there are no provisions for non-cash recipients.

Recommendation: The State should take immediate action to assure compliance with Federal regulations requiring the availability of transportation.

II. ELIGIBILITY

Supplementing its coverage of the categorically needy (AFDC and SSI cash recipients) and the medically needy, California extends Medi-Cal coverage to virtually every optional category for which FFP is available. Several problems were identified, but perhaps the most significant is the following.

Transfer of Property Restrictions Imposed on the Aged, Blind and Disabled Medically Needy

Since California has chosen to extend Medicaid coverage to its entire SSI and SSP population without application of transfer of property restrictions, it is not legally permissable for the State to impose such restrictions on its aged, blind and disabled Title XIX medically needy population.

> Recommendation: Absent pertinent changes in the Medi-Cal program or federal regulations, California should amend its program to eliminate the transfer of property restrictions it imposes on the aged, blind and disabled medically needy.

III. REIMBURSEMENT

A. Cost of Inpatient Hospital Services

Medi-Cal payments to county and community hospitals for inpatient care are increasing at an alarming rate. In response, DHS has proposed at least two separate methods of modifying the present reimbursement system - one limiting reasonable cost increases to a percentage, and another contracting with selected hospitals on a prospective basis.

> Recommendation: We recommend that DHS continue its efforts to develop an alternative hospital reimbursement method designed to maintain high quality of care as well as efficiency and economy.

B. Comparability of Reimbursement Amounts Between Medi-Cal and Medicare Programs

Although federal Medicaid regulations require that rates paid for medical procedures not exceed those paid by the Medicare program, the State has not compared amounts allowable under Medi-Cal with amounts allowable for the same procedures under Medicare in California.

> Recommendations: The medical service reimbursement amounts under the Medi-Cal and Medicare programs should be compared, and for any procedures identified for which Medi-Cal pays more, DHS should establish controls in their claims processing system to limit reimbursement to not more than the Medicare rate. Also, whenever either Medicare or Medi-Cal payment rates are updated, this process should be repeated.

C. Reviews of Pharmacy Operations

In August, 1978, the State discontinued routine reviews of pharmacies, primarily due to the California Pharmaceutical Association (CPhA) suit against the State charging that the sampling techniques used in reviews were improper. With the discontinuance, CPhA agreed to withhold its suit against the State. State records show that reviews resulted in recoveries exceeding $3 million in the 2 years ending 6/78. The State estimated the cost of making these reviews at about $500,000.

Recommendation: Given the past success of pharmacy reviews, the State should take whatever steps are necessary to reinstate reviews of pharmacy billing practices.

D. Common Audits

Currently there is no Title XVIII/Title XIX common audit agreement for auditing California providers serving both programs, though negotiations are under way.

Recommendation: The State should continue to work with the Medicare fiscal intermediaries, with the assistance of the federal Medicare and Medicaid Bureaus, to implement a comprehensive common audit system.

IV. EPSDT

Under federal regulations, all State Medicaid programs are required to include provision of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services for all eligible children under age 21. In California, EPSDT services are included in the Child Health and Disability Prevention (CHDP) program.

Inadequate Number of Children Screened

From July 1977 to June 1978, California reported complete EPSDT screens for less than ten percent of the eligible children in the State. Reasons for this include a provision which allows providers to bill either under the regular Medi-Cal system or under the CHDP system, improper counting of some screens as incomplete, screens not counted due to backlogs, and no counts for children screened in institutional settings since few hospitals will agree to manually process the forms.

Recommendations: The State should make the current CHDP reporting and billing system as efficient and accurate as possible, including provision of a paid claims tape of all claims paid by the CHDP unit to the new fiscal intermediary by 11/79 to permit unified reporting, and automated check-write to increase efficiency of the total operation. In addition, the State should replace dual provider agreements and require participation in the CHDP program as a condition of participation in Medi-Cal, or develop a single billing form for use for all recipients under age 21.

V. UTILIZATION

Federal regulations require that a State Medicaid agency have in place an effective program of control over the utilization of inpatient institutional services.

A. Professional Standards Review Organizations

Federal legislation mandates the use of Professional Standards

Review Organizations (PSRO) by States as part of the Utilization Control system. These organizations have the responsibility, once a Memorandum of Understanding (MOU) has been signed with the State Medicaid agency, to make final determinations about whether medical care provided was medically necessary. If it is determined not to be necessary, no Medicaid payment may be made. California has signed MOUs with only nine of the 23 PSROs eligible to provide binding review.

> Recommendation: In order to comply with Section 1155(a)(1) of the Social Security Act, the State should negotiate MOUs with the 14 PSROs currently ready to provide review.

B. State Operated Facilities - Level of Care

Both State central office and State mental hospital staff indicated that there exists an Intermediate Care Facility for the Developmentally Disabled (ICF/DD) level of care, but no evidence was found to document certification for such a level.

> Recommendation: DHS should make every effort to ensure that all State operated mental hospitals are properly certified for the level of care for which recipients are receiving services. This is especially critical in the ICF/DD area as it raises the question as to whether such patients are properly classified. This has implications for staffing, proper care and space requirements, and composition of the Independent Professional Review Team.

C. Medi-Cal Funded Positions in State Hospitals

The assessment team was informed by State staff that Medi-Cal funds 45 positions in 9 state institutions primarily for the developmentally dsiabled. It was stated that individuals in these positions report to the administrators of the individual institutions, and work in a supervisory capacity and not in the treatment of patients; their specific role was never clearly defined. However, admission review, continued stay review and annual medical review are conducted by staff of the Medi-Cal Field Offices,and none of their responsibilities have been eliminated as a result of these Medi-Cal funded on-site staff. Thus it appears the State is claiming FFP for staff either involved in duplication of effort or not functioning in the administration of the Medi-Cal program.

> Recommendations: Personnel in Medi-Cal funded positions in State institutions must perform Medi-Cal related functions, and should report to senior level State staff rather than to the hospital administrator of the facility in which they work. The State must ensure that personnel in these positions do not duplicate activities performed by Medi-Cal Field Office staff. The State must further ensure that the costs attributed to these positions are allocated between Medi-Cal and non Medi-Cal functions and the Medi-Cal costs are claimed for FFP at the 50% rate.

VI. FRAUD AND ABUSE

Two distinct departments within the State have responsibility for overall control of fraud and abuse in the Medi-Cal program: DHS and the Office of the Attorney General, which includes a newly established Medi-Cal Unit.

A. Beneficiary Verification of Services

DHS uses the Beneficiary Explanation of Medi-Cal Benefits (BEOMB) statements to verify services billed to Medi-Cal. BEOMBs are mailed to a random sample of 2% of the total recipients receiving Medi-Cal services, but because of poor wording and inaccuracies in the data supplied, the program has failed to yield any successful leads.

Recommendation: DHS should reevaluate the BEOMB program, particularly with respect to screening, sampling, accuracy and readability of the BEOMB data.

B. Computer Reports

The quality of computer generated reports from the old fiscal intermediary, which serve as leads for the Surveillance and Utilization Review Section (SURS) reviews, needs to be improved.

Recommendation: SURS should continue to work with the new fiscal intermediary to ensure that future reports meet SURS' needs.

C. Medi-Cal Fraud Unit Staffing

The Fraud Unit is hampered by a shortage of experienced professional personnel, plus an unevenly distributed caseload.

Recommendation: The State should review the workload distribution of the regional offices.

D. Notification of Penalties

Federal Regulations require the State to notify providers and recipients of penalties for fraudulent acts.

Recommendation: The State should authorize the release of an appropriate Medi-Cal Bulletin.

VII. CLAIMS PROCESSING

Since 1966 the State has contracted with the same fiscal intermediary, Medi-Cal Intermediary Operations (MIO) - encompassing Blue Cross North, Blue Cross South and Blue Shield - for its claims processing activities. Now they are in the process of an 18-month cross-over period during which Computer Sciences Corporation (CSC) will become the major FI.

A. Erroneous Payments

The effectiveness of edits and audits employed by the FI could not be verified without a statistically valid claim sample. State Certification Office representatives found evidence of duplicate payments, conflicting policies on payments for certain procedures by the different FI location, and erroneous payment situation existing due to inclusion of 1969 Relative Value Studies (RVS) codes in the data base for institutional providers and the edit for all providers to bill using 1974 RVS codes.

> Recommendation: DHS should perform a follow-up focus type review keying on erroneous payment situations already identified by the State Certification Office on-site representatives, to determine whether or not efforts should be initiated to recover erroneous payments made.

B. SURS Reports

Blue Cross North and South are responsible for processing and monitoring provider claims for inpatient and outpatient hospital services, but SURS reports for these claims are inadequate. MIO is unable to detect provider abuse of a specific procedure using the Medicaid Management Information System reports - i.e., without manually screening individual claims or using contractor-generated special reports.

> Recommendation: The State should develop a schedule, convert selected MIO provider history files to the CSC format, and then run this data through the new CSC advance SURS subsystem. Results from these runs, for which FFP is available at 90%, should be used to follow-up on provider fraud and abuse undiscovered in the past.

VIII. THIRD PARTY LIABILITY

Federal regulations require a State Medicaid agency to take all reasonable measures to determine the legal liability of third parties to pay for care and services made available to beneficiaries of the program. Where such legal liability is found to exist, the State is required to seek reimbursement to the extent of such liability.

A. Identification of Beneficiaries with other Health Insurance

The State has not taken all reasonable measures to maximize collections from liable third parties, specifically health insurance companies. In 1978 a three county experiment demonstrated that more effort at the time of application (or redetermination) for Medi-Cal eligibility would identify more persons with health insurance and/or produce more complete information on available health insurance, therewith enabling more bills to be sent. The pilot project report estimated that with the expenditure of an additional $2.8 million, an estimated increase in collections up to $16.6 million per year could be achieved.

Recommendation: The State should provide necessary additional funds, create the systems, and provide the necessary training to install this system state-wide.

B. Staffing of Units Related to Health Insurance Collection Activities

The State has not kept the units related to health insurance billing and collection activities fully staffed. As a result, several activities, such as increasing collection activity, cannot be performed and others must be delayed.

Recommendation: The State should ensure that the Recovery Section is fully staffed, and that computer programming support is adequate to meet its needs.

C. Post-Payment Recovery Action

Considering staff shortages and the need to keep workload within the ability of staff to do the work, the Recovery Section recently raised the minimum amount of claims that would be billed to an insurance company from $100 to $500. This increase was judged to materially reduce the amount of paper work in the billing process, and at the same time not significantly affect the amount of recoveries. However, choosing not to try to collect payment less than $500 could add up to substantial losses of federal and State funds.

Recommendations: The State should determine how much money is not being billed because of the $500 minimum before a claim is submitted to an insurance company. By applying the historical experience of 10% collections, a reasonable estimate of potential dollars lost could be developed. If this is substantial, one of several options should be considered - e.g., requiring providers to bill insurance companies first and then to bill Medi-Cal only for any additional monies due; or, a less desirable option, reducing the State billing level to $50 or a level where costs effectiveness can be demonstrated.

D. Recoveries from Accident or Injury Cases

In looking for third party liability, certain diagnostic codes which may indicate accident or injury cases are used to identify claims where there is a possibility of collection costs from the liable party. MIO currently uses a file of diagnostic codes against which paid claims are matched to determine potential third party recoveries, but no studies have been made to determine if this results in recoveries or a great deal of paperwork with no pay off. Also, no data has been developed to show if third party liability cases from other sources, which accounted for 39% of new cases added to the Accounts Receivable File during a recent period, contain diagnoses which are not in the current file of codes used.

Recommendation: The State should perform two studies - one to determine the pay-off from diagnostic codes currently used and to delete those which are not productive, and another to determine if additional codes should be added to the file.

IX. LONG TERM CARE

Medi-Cal provides a full range of long term care services in general skilled nursing facilities (SNFs) and intermediate care facilities (ICFs) and in specialized facilities for developmentally disabled and mentally disabled individuals. The State is also beginning to develop Adult Day Health Care Centers as a regular part of the Medi-Cal program.

A. Shortage of Long Term Care Beds

SNF bed availability fluctuates statewide with one area, San Francisco, always experiencing a shortage, other counties such as Fresno, San Bernardino, San Diego and Riverside sometimes having problems, and Los Angeles and San Jose usually having an adequate number of SNF beds. ICF beds, however, are in short supply throughout the State.

Recommendation: Specific level of care criteria, rather than professional judgment alone, should be used to determine appropriate patient placement. Also, to help stimulate the supply of ICF beds, Medi-Cal should review ICF reimbursement rates to assure that they are cost related. Finally the State should work with health planners and provider groups to encourage development of additional ICF beds.

B. Home Health Care Services (HHCS) Inaccurately Defined

Medi-Cal regulations define home health services as skilled nursing services and at least one therapeutic service such as physical, occupational or speech therapy. This is contrary to federal regulations which do not make the receipt of PT, OT or ST at home dependent upon the need for skilled nursing services.

Recommendation: The State should revise its regulations so that HHCS are provided to all individuals in need of such care without being restricted to those who also need skilled nursing services.

X. FAMILY PLANNING

The State's current system for identification and documentation of family planning, sterilization and abortion services is weak. Without adequate procedures for the identification of these services, the State has not been able to sufficiently document services to assure proper claiming of FFP at either 50 or 90%.

Recommendation: The State should take immediate steps to implement its proposed or alternate Family Planning Reporting System to support all claims for family planning, sterilizations and abortions.

XI. PHP/HMO

A. Department of Health Services/Department of Corporations Coordination

DHS and DoC have dual responsibility over the regulation and monitoring of prepaid health plans/Health Maintenance Organizations (PHPs/HMOs) in California but they do not coordinate their activities sufficiently to allow the contractors to satisfy all obligations to each department. Specific problem areas are execution of subcontracts, use of appropriate marketing materials, and compliance with required general and administrative expense limits.

Recommendations: DHS and DoC should develop together language for subcontracts and marketing brochures that is acceptable to both departments, and should coordinate the review of these materials to eliminate duplication and delays. Also, DHS should clarify for contractors the required general and administrative expense levels which will meet DoC requirements, or revise its regulatory reliance on DoC's determination and enforcement of appropriate general and administrative expense levels.

B. Control Over Duplicate Payments

The State's current eligibility system does not prevent receipt of services from regular Medi-Cal providers by PHP/HMO enrollees for whom the State has paid an enrollment fee. Thus the State could be paying for services twice. Since the State claims FFP for these services, Federal funds should be refunded by the State for costs of all services provided to PHP/HMO enrollees by the regular fee-for-service program. Modifications to the system have been proposed by DHS staff but not acted upon as yet.

Recommendations: The State should determine the amount and reimburse HEW for any improper fee-for-service payments made for PHP enrollees. Also, DHS should immediately institute a system for resolution of this problem.

REGION IX

DEPARTMENT OF HEALTH, EDUCATION & WELFARE

HEALTH CARE FINANCING ADMINISTRATION

MEDICAID BUREAU

INTRODUCTION

CALIFORNIA STATE ASSESSMENT

INTRODUCTION

Purpose

The purpose of this report is to present the findings and recommendations of the Region IX Medicaid Bureau assessment of the California Medi-Cal program. State assessment reviews were established to provide an overview of a State's Medicaid program and to identify potential problem areas within the current State program, as well as to offer recommendations on how the State could seek solutions and/or improvements for specific problem areas identified. Assessment reports are directed to HCFA Central Office and Regional Offices, the State's Governor and top management, Federal and State Legislative offices and provider and consumer groups.

Method

The field work for the California State Medicaid Assessment began in August 1978, and continued through March, 1979. The review was done in twelve segments, by teams composed generally of Regional Medicaid staff assisted by staff of the Medicaid Central Office and other Regional HCFA components. Team members met with various levels of staff from the Department of Health Services, as well as other groups associated with the Medi-Cal program (e.g., fiscal intermediaries, county staff, provider groups, and consumers) to observe whether the State has procedures in place to run the program and, if so, how well they are operating. Documentation and fact finding were the core of the assessment technique, though many subjective observations and analyses were also necessary.

Each section of the full report was prepared by the team covering that program area and, as such, each section stands alone. Due to this, there is some overlap of data and discussion items and, in addition to findings and recommendations, each may have an executive summary, preliminary comments and/or substantial background material.

Background

Medi-Cal, as the California Medicaid program is called, was implemented through State Legislation in November, 1965 and became effective in March, 1966. Prior to the start of Medi-Cal, indigent Californians had been provided health care services through a variety of different programs administered by the counties. With the advent of Medi-Cal, a wide range of health benefits was provided uniformly to those individuals throughout the State whose income and resources were insufficient to meet the costs of medical services without jeopardizing the person's or family's self-maintenance and security. The Medi-Cal program is administered by the State in cooperation with the federal and county governments.

From the program's inception, Medi-Cal experienced ever expanding program costs, primarily as a result of spiraling growth in caseload, utilization rates, and hospital costs. A Medi-Cal Reform Plan (MRP) was enacted by statute in October, 1971 with the objectives of developing an equitable statewide eligibility system, a uniform schedule of benefits for eligibles within a strong system of utilization and quality controls, and an improved system of health care delivery and health care financing for the program.

Although there have been no legislative revisions of the Medi-Cal program even approaching the magnitude of the MRP changes of 1971, portions of the program continue to be modified because of federal and state legislation and regulations or departmental efforts to simplify and improve the program. Examples of more recent changes in the program include the following:

a. Due to the 1972 federal legislation creating Professional Standards Review Organizations (PSROs) to perform quality and utilization review for medical services provided to Medicare and Medicaid beneficiaries, California presently is modifying its utilization review and claims processing systems to accommodate gradual implementation of PSROs.

b. The 1976 statutes required the Medi-Cal program to implement a uniform statewide schedule of maximum reimbursement for physician servcies which emphasized primary and maternity care services.

c. In 1976, as a result of a recommendation of the Medi-Cal Eligibility Simplification Task Force, the Department modified through legislation its criteria for the medically needy and medically indigent categories so that the eligibility requirements for the two categories were identical.

d. The 1978 passage of Proposition 13, reducing property taxes and consequently greatly reducing county revenues, has led to substantial cutbacks in funds available for health care services. To date this has been realized mainly in staffing reductions; future effects on the Medi-Cal program are now under review.

Other Medi-Cal changes are under consideration as part of the State's proposals for restructuring the health care system. These changes include certifying selected hospitals and laboratories to participate in Medi-Cal; purchasing drugs and appliances on a volume purchase plan; and encouraging recipients to use PHPs, community clinics, and hospital-based primary care programs.

The laws governing the Medi-Cal program are included within the California Welfare and Institutions Code, and regulations are included in Title 22 of the California Administrative Code. The single

State agency administering the Medi-Cal program is the Department of Health Services, which was established July 1, 1978 pursuant to State legislative action reorganizing the umbrella Health and Welfare Agency.

Statistical Overview

In 1978, California population was 22,297,000 and over 3.4 million beneficiaries received Medicaid services. (See following table for beneficiaries and costs by type of service.) Total expenditures (Federal and State) exceeded $2.4 billion of which $161 million was for administration. Vendor payments to general hospitals, skilled nursing facilities, physicians and pharmacists accounted for 78% of the total Medicaid dollar.

Medicaid expenditures in California have increased 27% over the last two years. Federal and State expenditures in 1976 amounted to $1.9 billion; 1977 totaled $2.3 billion. The State is forecasting expenditures in excess of $3.0 billion in FY 1979. In addition to Medicaid expenditures, in 1978 the State paid $486 million for services to 574,000 Medically Indigent beneficiaries, for which no Federal funds are available.

CALIFORNIA

Recipients and Expenditures By Type Service

F.Y. 1978

		Recipients		Expenditures [2/] (Millions)	Percent
Totals		3,436,194 [1/]		$2,356.8	100.0%
Inpatient Hospital		511,825		854.5	36.3
General	508,105		$829.4		
Mental	3,720		25.1		
SNF		127,277		526.1	22.3
ICF		8,450		25.2	1.1
Physician Services		2,500,098		345.9	14.7
Dental Services		956,620		97.4	4.1
Other Practitioners		684,175		44.9	1.9
Outpatient Hospital		1,441,635		132.7	5.6
Clinic Services		152,740		13.6	0.6
Lab & Radiology		2,037,996		79.9	3.4
Home Health Services		11,240		2.4	0.1
Prescribed Drugs		2,313,385		147.8	6.3
Family Planning		288,089		52.6	2.2
Other Care		271,380		33.8	1.4

[1/] Unduplicated

[2/] Does not include Administration

Source: HCFA - 2082

REGION IX

DEPARTMENT OF HEALTH, EDUCATION AND WELFARE

HEALTH CARE FINANCING ADMINISTRATION

MEDICAID BUREAU

Administration and Management

CALIFORNIA STATE ASSESSMENT

October 30-November 8, and December 4-7, 1978

Participants: Joanne Walker (RO/Medicaid)
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CALIFORNIA STATE ASSESSMENT

ADMINISTRATION AND MANAGEMENT

I. Introduction

From October 30 through November 8, and from December 4 through December 7, 1978, a Medicaid Bureau assessment team conducted a review of the administration and management of the Medi-Cal program. This segment of the California State Assessment focused on the Department of Health Services, including its organization, functions, responsibilities and procedures, as well as the impact on the Medi-Cal program of other agencies and organizations. In the course of this review, the team interviewed executive and general staff of the Department of Health Services, the Chief of AFDC Policy Coordination with the Department of Social Services, the Administrators of two of the State's twelve Medi-Cal Field Offices, staff of two of the fifty-eight County Public Welfare Offices, staff of a federal Social Security District Office, the Chairman of the State's Medicaid Advisory Committee, and representatives of eleven welfare recipient organizations. During the first week in December, records were reviewed in two additional Medi-Cal Field Offices.

As the organization, structure and staffing of the Medi-Cal program are constantly changing, for the purposes of this review an arbitrary cut-off date of December 8, 1978, was used.

The major findings of this segment of the assessment indicate that most problems occur as a result of the wide fragmentation of authority and control within the Medi-Cal program, the need for better coordination and communication among all components involved, and a lack of sufficient and specific enough written material and guidelines for both staff and recipients. Proposition 13, with the subsequent freeze in hiring and cutback in staff allocations, has also had a serious effect on the operation of the program. Finally, the major program recommendation is for a change in the provision of and payment for transportation necessary for medical care.

II. Organization

A. General

The Medi-Cal program is administered by California's Department of Health Services (DHS), which is the Medicaid single State agency. Within DHS, the three divisions under Medical Care Services carry the bulk of the program and deal exclusively with Medi-Cal, while most of the other divisions and offices in DHS impact on or administer a part of the Medi-Cal program in addition to other programs. DHS itself is one of ten departments under an umbrella organization, the California Health and Welfare Agency, of which most components also have some direct relationship to or impact upon Medi-Cal. In addition, there are a number of outside agencies and organizations which, through contracts, interagency agreements or simply the authority of the California State governmental structure, have a substantial impact upon the administration of the Medi-Cal program. (See Appendix A for organization charts).

B. Structure and Interrelationships

1. Department of Health Services (DHS), the single State agency (Appendix A.2)

The current Director of DHS is Ms. Beverlee A. Myers. She has held this position since the inception of DHS on July 1, 1978, after having served for three months as a consultant to the former California Department of Health. Previously, she was a consultant to the U.S. Senate Committee on Health Care, and from 1973 to 1976 was Deputy Commissioner for Medical Assistance in the New York State Department of Social Services.

Reporting directly to Ms. Myers are three Chief Deputy Directors, each of whom directs from three to five divisions or offices. In addition there are two divisions and three offices which report directly to her. Altogether, there are approximately 3700 positions within DHS.

Of these 3700 positions, approximately 900 are under the Chief Deputy Director for Medical Care Services. This group, which deals exclusively with Medi-Cal and thus is the major focus of the assessment, is comprised of three divisions:

- the Medi-Cal Division (Appendix A.3), encompassing field services, third-party liability recovery, fiscal intermediary operations, and the Medi-Cal procurement project;

- the Medical Care Standards Division (Appendix A.4), encompassing benefits, policy and standards, eligibility, the PHRED Project, rate development, and EPSDT/CHDP; and

- the newly formed (November 1978) Alternative Health Systems Division (Appendix A.5), encompassing prepaid health plan/health maintenance organization contracts, and pilot projects.

- There has also been the recent addition of a Medical Services Unit reporting directly to the Chief Deputy Director. This group encompasses the Support Services Branch which was in existence during field work portion of the assessment process.

From July 1 to November 17, 1978, Mr. Bruce Yarwood was Acting Chief Deputy Director for Medical Care Services, as well as Deputy Director of the Medi-Cal Division and Acting Deputy Director of the Medical Care Standards Division. Therefore, staff for this entire area had been working very closely together and, as such, it was frequently difficult to separate out specific functions and responsibilities within a branch or division. Though this did not appear to be a problem, we anticipate a more distinct division of the workload with the separate division directors. At present, the position of Chief Deputy Director for Medical Care Services has not been filled, but many of those duties have been temporarily assumed by Barry Dorfman, M.D., Assistant Director of DHS. The two original divisions are now headed by individuals who have come from outside DHS, and the third, newly designated division is essentially the old Alternative Health Systems Branch of the Medi-Cal Division.

The Chief Deputy Director for Preventive Health Services heads up three divisions, all of which impact to varying degrees on Medi-Cal:

- the Public and Environmental Health Division performs laboratory and X-Ray certifications;

- the Licensing and Certification Division is responsible for licensing long term care facilities (SNFs and ICFs); and

- the Rural Health Division deals with rural health clinics.

Also, the Community Health Services Division, administering the Child Health and Disability Prevention program (CHDP, California's EPSDT program) was included here until its December 1978 move to Medical Care Services as a branch.

The Chief Deputy Director for Policy, Planning and Enforcement heads up five offices, four of which relate to the Medi-Cal program:

- the Office of Legal Services handles all Medi-Cal legal work;

- the Office of Legislative Liaison handles all Medi-Cal legislation (in 1977, there were over 400 Medi-Cal bills introduced, many of which were amended up to six times);

- the Office of Planning and Evaluation handles management consultation for the Medi-Cal program (e.g., a prudent buyer study, a cost containment study); and

- the Office of the Executive Secretariat, more commonly known as the Office of Regulations, maintains the official Medi-Cal State Plan and coordinates, reviews and advises the Director of DHS on all Medi-Cal State regulations.

Finally, within DHS are those divisions and offices reporting directly to the Director of DHS which also impact on Medi-Cal:

- the Administration Division handles Medi-Cal's budget, accounting, ADP, and some training and personnel functions;

- the Audits and Investigations Division handles fraud and abuse identification, quality control, SURS, and audits for the Medi-Cal program;

- the Office of Civil Rights handles affirmative action and Section 504 (non-discrimination against the handicapped);

- the Office of External Affairs serves as a link with Medi-Cal consumer groups, and staffs the State's Medicaid Advisory Committee; and

- the Office of Public Information deals with the press and is a contact point for public inquiries regarding Medi-Cal.

2. Health and Welfare Agency (Appendix A.1)

Within the umbrella organization, the Health and Welfare Agency, there are a number of other departments which interact with DHS on the Medi-Cal program. For example:

- the Department of Rehabilitation,
- the Department of Mental Health,
- the Department of Developmental Services and,
- most notably, the Department of Social Services (DSS), which determines AFDC eligibility.

3. Other State Organizations

Outside the Health and Welfare Agency there are numerous State organizations which impact on the administration of the Medi-Cal program to varying degrees. For example:

- the State Personnel Board, which administers the State's merit system;
- the Attorney General's Office, which handles fraud and abuse investigations;
- the Controller General's Office, which will soon begin writing all Medi-Cal checks to providers;
- the State Board of Control, which hears Medi-Cal claims and appeals from providers;
- the Department of General Services, which must approve all contracts;
- the Department of Corporations, which has approval authority for PHP/HMO marketing materials, and which licenses PHP/HMO enrollees; and
- the Department of Finance (DoF), which plays a very major role as they must approve all contracts, sign off on all Medi-Cal regulations before they can go into effect, and generally approve any Medi-Cal change or action affecting the expenditure of State funds.

4. Fiscal Intermediaries (FI)

Outside the State government itself are the Medi-Cal fiscal intermediaries, under contract with DHS. Such current contracts include:

- Medi-Cal Intermediary Operations (MIO), which encompasses Blue Cross of Northern California, Blue Cross of Southern California and California Blue Shield, and is the "old" Fiscal Intermediary (FI), to be phased out by March, 1980;

- Computer Sciences Corporation (CSC), the "new" FI being phased in during the eighteen month period from September 1978 through February 1980; and

- California Dental Services (CDS)

With the gradual change from MIO to CSC as the major fiscal intermediary, the State will itself assume five functions previously under the MIO contract. These are checkwriting, provider certification, the SURS report review and initial case development, medical quality assurance, and third party liability recovery.

5. State Medi-Cal Field Offices

Located throughout California are twelve Medi-Cal Field Offices, each headed by an Administrator who reports to the Field Services Section in the Operations Branch of the Medi-Cal Division, DHS. The two primary functions of these field offices are to carry out medical reviews in skilled nursing facilities (SNFs) and intermediate care facilities (ICFs), and to serve as reviewers of providers' requests for prior authorization.

The periodic medical reviews of all Medi-Cal beneficiaries in participating SNFs and ICFs are conducted to determine each patient's health needs, as well as the adequacy of the care being provided. The medical review teams from the field offices are comprised of physicians, registered nurses and a social worker.

Under California's Treatment Authorization Request (TAR) System, providers must request authorization from a field office prior to providing most Medi-Cal services. When a TAR is received in a field office, it is referred to an appropriate consultant (physician or nurse) for review as to the completeness and appropriateness of treatment for the diagnosis given, and the scope and duration of the treatment recommended. In urgent cases, verbal authorization may be given by phone, but the provider must follow that up with a written TAR. If the TAR is complete, the service a covered benefit, and treatment medically justified, the TAR is approved and returned to the provider. The provider in turn attaches the approved TAR to his claim and submits both to the fiscal intermediary for payment. However, if there is a problem with the TAR, the consultant may (1) modify the TAR to meet regulations; (2) return the TAR to the provider for additional information, whereupon the provider may or may not re-submit the TAR; or (3) deny the TAR, stating the reasons, and return to the provider. In the case of denial, the provider may appeal the case to the Field Office Administrator, and then to the Field Services Section in Sacramento.

An additional function of the field offices under the TAR system is the onsite review of continued stays in acute hospitals. This is performed by nurse consultants who visit these facilities daily, and have the authority to approve continued stays. However, if the case is questionable or a denial seems appropriate, it must be referred to a physician consultant. With implementation of the PSRO program, this function will be discontinued by the State.

Staff of the field offices work mainly with providers, and generally have very little direct contact with recipients, though some do meet periodically with consumer groups, such as welfare rights organizations, and have established community communication services. Field offices do not deal with reimbursement issues nor do they generally provide information on the scope of benefits provided under Medi-Cal. There is some communication with county welfare offices, perhaps two or three calls per week, and occasional contact with Social Security district offices. There is substantial contact among staffs of the twelve field offices, generally by telephone. Monthly meetings of the Administrators are held in Sacramento with the Field Services Section and the Benefits Branch, with frequent telephone calls between meetings; Appendix B.1 indicates the written communications provided field offices. Both Administrators interviewed indicated that Medi-Cal policy was fairly well spelled out.

6. County Welfare Offices (CWO)

Each of California's fifty-eight counties has a County Welfare Office which in turn, depending on the size of the county, may have a number of branch offices. These offices make eligibility determinations under four major programs: Aid to Families with Dependent Children (AFDC), Medi-Cal, Food Stamps and General Relief. CWO employees report to their County Board of Supervisors but, because of their involvement in these various programs which fall under separate departments in the State government, they receive instructions from a number of different sources. For example, with respect just to Medi-Cal beneficiaries, DSS issues eligibility determination instructions for those entitled because they are AFDC recipients, and DHS issues eligibility determination instructions for the Medically Needy Only (MNO). And, while the Social Security Administration in their own district offices determines Medi-Cal eligibility for Supplemental Security Income (SSI) recipients, the CWO workers must frequently deal with their problems and inquiries and thus must, to some degree, understand the SSI program also.

In addition to program guides and written material provided to CWOs (see Appendix B.2), the counties have their own guidelines also. With respect to direct liaison between the CWOs and DHS, there are seven Field Representatives in the Eligibility Branch of the Medical Care Standards Division who cover the fifty-eight counties, making two to four regular visits per year, plus others as needed. There is also substantial telephone contact between Field Representatives and the CWOs.

Depending on the size of a CWO or branch, an eligibility worker may deal with all programs or may specialize in one particular program. Because of staff shortages, the explanation of Medi-Cal benefits given to recipients tends to be very brief, and in many cases - particularly for AFDC cash recipients - this may not be discussed at all. Brochures regarding Medi-Cal are given to AFDC and MNO recipients in the CWOs, but these, too, vary from office to office. (See Appendix C for examples of forms and handouts).

7. Social Security District Offices (SSA DO)

As applications for SSI cash benefits, and Medi-Cal for those recipients, are taken and processed in federal SSA

DOs, many of the Medi-Cal brochures handed out by CWOs should also be available in SSA DOs. However, in fact it appears that the availability of both information and handouts varies greatly from office to office. SSA DOs frequently refer their Medi-Cal recipients to the CWO if further information is requested.

C. Problems and Conflicts between DHS Headquarters and the Field

In discussions with staff of both the Medi-Cal Field Offices and County Welfare Offices, it became apparent that they all share some common or similar problems with respect to information and communications involving DHS headquarters, providers, recipients, and each other. Specific problems frequently mentioned were the needs for better exchange of information between the field offices and the CWOs, as well as with DHS; a clear numbering system for all regular issuances from DHS, to assure receipt of all appropriate material; and some method of assuring that Medi-Cal Bulletins are received in these offices no later than they are received by providers. Also expressed was the need for more and better information on the Medi-Cal program in the form of training materials for their staff, and handouts and brochures for the public, as well as a source of information for both providers and recipients regarding scope of benefits.

Other problems and conflicts discussed tended to be more specific to one or the other of these offices, as indicated below.

1. Medi-Cal Field Offices

A major problem currently being faced in many field offices is that of staffing, due to the freeze in hiring imposed as a result of Proposition 13. This appears to be a particular problem with respect to clerical staff, and one which is further aggravated by the prohibition against hiring even temporary help. The only recourse is to "borrow" clericals for short time periods from another field office. This source of help is seldom available. One of the problems resulting from a reduced clerical staff is the substantial increase in the turnaround time for TARs. For example, in one field office with an increase from an average of 5 days to 24 days, telephone requests for emergency (verbal) approvals consequently increased substantially, requiring still more staff time, which in turn increased the overall turnaround time--thus creating a vicious circle within the TAR system. Staff reductions have also led to serious problems in conducting the periodic medical review required for all SNFs. This creates an apparent compliance issue, because for several facilities there was no social worker available to constitute a complete medical review team.

Another major problem area reflected in the field offices is that of criteria and guidelines for use by the medical consultants in their review of TARs. First, the State has never provided specific written criteria. As a result of at least one study of the TAR system completed by OPPR (see discussion in Section VIII on Monitoring and Program Appraisal), it was agreed that such criteria were necessary. The first twenty sets of criteria on which work was begun were submitted to various groups for review, but have never been completed and issued to the field offices for use. With current cutbacks, DHS staff indicated it was unlikely that any further sets would be established within the next year. A related problem mentioned by field office staff was that even the broad policy statements and guidelines for TAR review issued by DHS staff for the medical consultants are not available to providers. If the guidelines were available, this could improve the understanding of providers as to why certain services are approved and others are not, thereby decreasing both inappropriate requests and complaints regarding denials.

2. County Welfare Offices

The CWOs probably encounter the most severe problems and conflicts with headquarters in Sacramento, due to the county position as a recipient of instructions from so many different sources. A major problem for CWOs with respect to Medi-Cal recipients is the lack of coordination between DHS and DSS. In addition to the difficulties raised by CWO eligibility workers having to work with different sets of eligibility regulations and manuals for AFDC and MNO Medi-Cal recipients, sometimes the State regulations are actually incompatible and it is frequently obvious that one department has not consulted with the other prior to issuing guidelines to the counties.

A major concern of those CWOs visited, especially San Diego, was the quality of the Eligibility Manual and guidelines provided by DHS. According to these CWO personnel, the DHS material lacks clarity and specificity --telling the counties what to do, but not how. Those interviewed said they are told to "interpret liberally" the instructions received, thus necessitating each CWO seeking its own legal interpretation, while guidelines contain such terms as "or similar" and "includes, but not limited to". Thus different counties may--and frequently do--interpret the material quite differently. Also, because of the lack of certain forms and/or the instructions for completing such, the counties are often considerably behind schedule in meeting DHS reporting requirements. (It should be noted that other counties, interviewed as part of the eligibility segment of the State Assessment, felt the Eligibility Manual was exemplary.)

Another complaint received was that of DHS headquarters asking the CWO for information and reports previously supplied. Although this requires additional county expenditures of time and money, the State claims it cannot afford to go back into its own records.

One concern expressed for which there appears to be little recourse is the necessity of dealing with retroactive changes due to court cases.

A number of problems were mentioned with respect to the two medi-labels and six proof-of-eligibility (POE) labels which are given monthly to recipients with their Medi-Cal cards. The two medi-labels are to be used for receipt of services not requiring prior authorization, and no additional medi-labels may be supplied. There is no limit on the number of POE labels, and once the six POE labels on the card are used, the provider may use a photocopy of the card as a POE label, or additional labels may be obtained through CWOs. However, the CWOs do not have the time and/or staff to follow-up on such requests, and there is the problem of lost or forgotten Medi-Cal cards, involving both types of labels. Tied in with these problems is that of the unduly long period (2-3 weeks) it generally takes for a MNO recipient to receive his/her Medi-Cal card following CWO verification that the required share of cost has been obligated for a given month. By the time the card is received, it is frequently no longer valid.

It should be noted that each CWO visited was very positive in expressing a good, ongoing relationship with the Field Representative assigned to them. They praised the prompt, understandable responses to inquiries and requests, and appear to rely heavily on this DHS contact for assistance and clarification of otherwise confusing and problematic information from the State.

III. Personnel

A. Staffing, Recruitment, and Hiring

As previously indicated, DHS encompasses approximately 3700 positions, both in Sacramento and in the field. (See Appendix A.2 for numbers of positions in specific areas). However, not all positions are currently filled and the situation appears to be worsening. Of the roughly 940 budgeted positions under Medical Care Services, over 13% are vacant. Because of Proposition 13, there have been severe restrictions on filling vacancies, including a freeze imposed last fall which prevented the State from filling any vacancy except by transfer within the State government. Also, recent proposals for cutbacks in Medi-Cal expenditures have been aimed primarily at cutbacks in staff.

The recruitment of physicians has been a particular problem for many years. Reasons for this include the low salary potential, generally from $37-42,000 per annum; the general image of State employees, which tends to be poor in the eyes of the public; and the job setting itself, basically on the fringes of the practice of medicine and with few hands-on positions involving direct patient contact.

There are also timing problems when a position is to be filled, as a listing of qualified eligibles must be received from the State Personnel Board, a procedure which has taken from four to six weeks for the past five years.

In the County Welfare Offices, which are outside DHS and the State government, staffing shortages create further problems for the Medi-Cal program, and have grown worse under Proposition 13.

B. Appraisals

All permanent employees receive (and sign) annual performance appraisals from their supervisors, including face-to-face interviews. In addition, all promotions require a supervisor's appraisal. Appraisal forms are composed by the State Personnel Board. (See Appendix D.)

A newly hired employee will be required to serve one of two types of probationary periods. One period lasts six months, during which the new employee receives an interim performance appraisal every two months. The other is a year-long probationary period during which the new employee receives an interim performance appraisal every four months.

C. Training

For new employees in Medical Care Services there is an orientation package and slide show presented monthly, in addition to individual training given by the immediate supervisor. There is also an advanced orientation program given by subject area for those employees needing additional training. This is generally given by Branch Chiefs.

The comprehensive employee development program for all Medical Care Services employees in Sacramento is called STAMP, the Skills Training and Maintenance Program. This has the dual purpose of maximizing the performance of each employee, and enhancing career development and enrichment opportunities. For each employee, the program begins with an inventory of skills, followed by training to develop those skills. Participation in the program is mandatory. Generally speaking, training aimed at solving problems within the Medi-Cal program and its administration takes precedence over the general interests of employees, and job-related sessions are given priority over career-related.

Currently, funds are not available for out-of-State training and travel, and there are similar restrictions for programs within the State but at a considerable distance from the employee's duty station.

IV. Management

A. Work Planning

Overall work planning in DHS begins with the Director meeting with the Chief Deputy Directors to establish annual objectives. The Chief Deputy Directors then meet with the Deputy Directors and Branch Chiefs to establish written goals and objectives.

The Directors and Branch Chiefs meet weekly as a group to discuss current issues and problems followed by individual meetings between the appropriate Director and each Branch Chief to go over specific assignments. In recent months, the changes in objectives and priorities due to Proposition 13 have created considerable turmoil including many personnel changes (both terminations and reassignments), which have substantially hindered work planning and the meeting of departmental objectives. However, it does appear that the basic goal-setting process includes substantial communication both up and down within the DHS hierarchy.

An improved working relationship with the State Legislature has been established with Ms. Myers' appointment as the Director of DHS. She herself frequently appears before legislative committees, and expects her top staff members to be well informed on current issues and available to the Legislature. This represents a substantial improvement over past administrations, when lower level staff were often called on to testify regarding bills for which the Department or Agency had not established a clear position. With a better relationship between DHS and the Legislature, support, approval and funding for specific objectives should be more easily obtained.

B. Correspondence

Incoming Medi-Cal correspondence is controlled in part by the way in which it is addressed. All items addressed specifically to Beverlee Myers are controlled in the Director's office. All other correspondence is handled by Support Services (now the Medical Services Unit). Controlled correspondence is numbered for control purposes and assigned to the appropriate Branch Chief for response. For correspondence from the Governor or the Legislature, a copy of the incoming item is filed as an additional control. The Support Services Branch Chief maintains a log of all controlled correspondence and checks each item the day after it is due. Most uncontrolled correspondence is handled by a letter writing unit within Support Services.

Generally, all legislative correspondence has a 5-day turnaround, and all else 10-days - unless there is some indication that the information requested is not needed until a certain date. If a major policy question requires additional time, an interim response is sent. In July, 1978, three out of every fifty letters were overdue, but by November, 1978 fifteen to twenty of every fifty were overdue, mainly because of staffing shortages. Support Services handles approximately 150-200 letters each month, without the aid of automatic typewriters. They do try to respond to some items by telephone, then documenting their calls. They also handle several hundred incoming telephone calls each month.

Control slips on pending correspondence are filed by number. The Records Information Center can retrieve prior correspondence by author's name, or provider or recipient, within minutes.

C. Policy Guidance and Coordination

The Office of Regulations in DHS receives copies of all regulations, action transmittals, and similar material issued by the federal government, and works generally in the policy guidance area. In the past, a Regulations and Compliance Coordinator handled the coordination of all Medicaid material, including preparation of an analysis of federal regulations and their impact on the Medi-Cal program, as well as the coordination of State plan amendments and any other items required by action transmittals. A circulating file is sent to all Branch Chiefs on a daily basis, indicating changes in federal and State regulations.

In August, 1978, with the retirement of this Coordinator, these duties were temporarily assigned on a part-time basis to the Support Services Branch Chief. However, because of its substantial impact on the Medi-Cal program, this area of assignment clearly requires a full-time individual. It also seems, as was agreed upon by all interviewed, that the individual in this position should report directly to the Chief Deputy Director for Medical Care Services, where immediate action on policy questions can be addressed, and access is readily available to all components in that area.

The official State Plan is maintained in the Office of Regulations, though most of the required work and coordination is done by the program staff - that is, in the divisions under Medical Care Services. The Governor's Office also reviews all State Plan amendments, though of the fourteen amendments submitted in calendar year 1978, no comments were received.

In addition to the materials sent from the Medicaid Bureau in Washington, D.C. directly to the Office of Regulations, many Medicaid documents, such as action transmittals and information memoranda, are also sent to the Director of DHS and/or the Deputy Directors. State staff suggested that the Regional Medicaid Bureau address all its important documents requiring a response or action to Ms. Myers specifically, and not simply to the Director, DHS, so as to make sure they reach her directly and are controlled within her office. This has now been done.

Within Medical Care Services, weekly staff meetings of all Branch Chiefs are held , at which a report is given of the Director's weekly meeting with the Deputy Directors. Also, copies of all correspondence are circulated among the Branch Chiefs on a daily basis. Below the Branch Chief level, communication seems to vary greatly, dependent on the individuals involved.

There is no overall Provider Manual established and maintained by the State, the closest thing being the Medi-Cal Bulletins put out by MIO, the outgoing fiscal intermediary. And, as each Bulletin may address a number of topics and an index is published only once or twice a year, they are generally difficult to use as a reference source. This situation is expected to improve with the change to the new FI and the State itself taking full responsibility for policy decisions involving the provider relations function. DHS will also be establishing a Medical Policy Manual to be used by the new FI. As previously mentioned, there is an Eligibility Manual, maintained by the Eligibility Branch and utilized by the CWOs in their eligibility determinations.

V. Relationships with Policy Makers

One problem area for DHS in its relationships with policy makers is the control exerted by the Department of Finance, at both the departmental and agency levels. DoF is one of eight departments which report directly to the Governor. With DoF's strong veto power over every regulation processed by DHS, there appears at times to be some question of which department is controlling the Medi-Cal program.

Each year DHS has an over-run of its budget and must go back to the Legislature for a supplemental appropriation. During this process, when funds run out, payments to providers are stopped, and thus services to recipients are curtailed.

VI. Consultants and Contracts

All consultants and contracts must be approved by the Department of Finance, the Department of General Services and the Personnel Board.

A. Consultants

The State utilizes the services of a consultant if it is in the best interest of the State and if such services and expertise are not available within the State Civil Service System. Most consultants are selected on a sole source basis, and the criteria for selection are spelled out in Section 1242 (2e) and (4) of the State Administrative Manual. Payment to consultants may be based on one of the following: a lump sum or fixed price for the total project; an hourly rate plus cost reimbursement, with a ceiling on the total project or contract amount; or daily compensation plus cost reimbursement, to work "when requested" during the term of the contract, with a ceiling on the total amount.

B. Contracts

Most contracts relating to the Medi-Cal program are with fiscal intermediaries and prepaid health plans, and as such will be discussed in other segments of this assessment report.

Contracts are let only when such services are not otherwise available and contractors are generally selected through a competitive bidding process. If there are extremely unusual contract requirements, a sole source contract may be made on the basis of proven ability to perform these specialized functions. Procurement guidelines are spelled out in Sections 1241-1247 of the State Administrative Manual. The Department of General Services has rejected contracts because they are not competitively bid. Monitoring requirements are spelled out in Section 1218 of the Manual, and the DHS liaison with the contractor is always someone involved in the particular aspect of the program being contracted for. Reporting requirements vary with the needs of individual contracts. (See Appendix E for specific DHS contract procedures.)

VII. Program Content

A review of California's Title 22 regulations against the federal Title XIX Medicaid regulations uncovered no problems or discrepancies. The covered services offered under the Medi-Cal program include all required Medicaid services and almost all optional services, making California's scope of benefits one of the broadest in the county. The only major category not included is private duty nursing.

No cutbacks or increased limitations have been made regarding services, though there is a possibility that this may be considered in the future as a result of Proposition 13. There has been one recent change in the State drug program, dropping barbituates from the drug formulary, but this was done for "good health" reasons, and not for cost containment. This particular change could be made under administrative authority and did not require legislation.

Legislation is generally required to increase or decrease the scope of Medi-Cal benefits. However, although basic Medi-Cal program requirements are established under State statute, many program provisions are in regulations rather than statute. Therefore, many program changes can be accomplished through a change in regulations, which is a process quite different from the legislative change process. To change Medi-Cal regulations, program staff begin by developing proposed regulations incorporating the changes The State then gives provider, advisory and advocate groups the opportunity to comment on proposed changes. Providers in particular are encouraged to comment during the developmental stages. Proposed regulations are published in major newspapers throughout the State, and there are public hearings on proposed regulations prior to final regulations being published. Proposed changes are also usually discussed in Medi-Cal Bulletins, which are sent to all providers. Recipients are generally notified of changes affecting them through "stuffers" included with their welfare checks and Medi-Cal cards, mailed monthly.

In the past California has experimented with cost sharing for some services, such as drugs, but found it was not cost effective. At present there are no deductible or cost sharing payments for Medi-Cal beneficiaries.

There is one group covered under Medi-Cal, the Medically Indigent Adults (MIAs), for which the State does not receive any federal funds. Medi-Cal is also providing certain abortion services for which they do not receive federal funding. Although California regulations on abortions were changed to be as restrictive as federal regulations, the Medi-Cal program is currently under a court order not to implement these changes.

There are certain Medi-Cal services which are exempt from the TAR system (as previously described in Section II B.5 on Medi-Cal Field Offices), or are treated somewhat differently. Physician office visits do not require a TAR, but visits relating to allergy, dermatology and psychiatry are limited to 8 in 120 days. Also, there are six Medi-Cal services which are exempt from TARs but do require use of one of the two medi-labels given to each beneficiary each month. These six are services provided by psychologists, chiropractors, audiologists, optometrists, podiatrists, and physical, speech and occupational therapists. However, except for psychologists and chiropractors, visits in addition to the two per month total may be requested and approved through the TAR system.

Due to problems encountered by Medi-Cal recipients in obtaining access to physicians, there has been an increase in the inappropriate use of hospital emergency rooms as a point of primary care. Therefore, emergency room care is reimbursed at the same rate as regular outpatient services, unless the claim is certified as a true emergency. Another move to combat this problem by improving provider accessability has been to reimburse physicians at a higher rate if they will see patients beyond the normal office hours of 8 am - 5 pm.

A. Transportation

The only major unsolved problem found with respect to coverage of services is that of transportation. Under Medi-Cal there are three levels of transportation needs:

(1) that which is medically necessary (basically, emergency services), which is covered by Medi-Cal through reimbursement to the ambulance service or other provider;

(2) regular transportation for medical services, which is considered to be included in the cash grants of the categorically needy (AFDC or SSI recipients); or

(3) transportation for those with "recurring special needs," for which the counties can provide special payment.

With respect to the first category, emergency or truly medically necessary transportation, there is no problem. With respect to the other two, there are many problems and we have received many complaints, both prior to and in the course of this assessment.

With respect to regular transportation, considered included in the cash grant, there is considerable confusion. First, it is a non-identified part of the cash grant, and as such is not based on a specific amount; and it is questionable whether or not the amount is adequate. Second, most welfare recipients are not informed that this is included. Finally, MNO recipients are even less likely to be aware that transportation is a factor included in the maintenance need amount than are cash grant recipients. This is because, while cash grant requirements state that transportation needs are considered in the grant amount, Medi-Cal maintenance need regulations simply list the total amount a family may retain for maintenance needs.

In order to obtain transportation under the "recurring special needs" program, a recipient first has to convince his/her case worker that such a special need exists. Then there is the problem of a rather stringent, frequently nonrealistic upper level on the amount which may be allocated for this ($10 per month times the number of persons included in the cash grant computation). And there is no "recurring special needs" provision for the MNOs. The final and perhaps major problem here is that, due to Proposition 13, a number of of counties have had to eliminate all special needs payments.

There are several law suits now pending against the State regarding transportation issues, in addition to a number of complaints which have been filed with the federal Office of Civil Rights.

VIII. Monitoring and Program Appraisal

Within DHS, under Medical Care Services, two branches perform monitoring functions. The Benefits Branch conducts management reviews of the twelve field offices, looking at such areas as medical consultant records for recent weeks, broken out by services requested and by individual physicians. However, it appears that these reviews, which are supposed to be done on an annual basis, are currently running several years behind schedule.

The other periodic intra-departmental review is by the Eligibility Branch, whose Field Representatives conduct quarterly reviews of the County Welfare Offices. The Field Representatives meet with the CWO's Medi-Cal liaison, review individual cases for error trends and conduct training workshops, in addition to providing technical assistance on an as needed basis. It appears that the Field Representatives generally do visit each CWO from two to four times each year.

There are also various types of audits and assessments of specific segments of the Medi-Cal program which are conducted on an ad hoc basis. These may be requested and/or conducted by DHS itself or by outside agencies and organizations. One example of an intradepartmental study is the OPPR (now the Office of Planning and Evaluation) review of the TAR system itself. As a result of the inconsistencies found from field office to field office, and from consultant to consultant, several changes were made. There are now monthly meetings between the field offices and the Benefits Branch to discuss the consistency of TARs, and there are also periodic meetings of the medical consultants. Also, written criteria and guidelines are being established.

Recent studies by outside agencies include that of the California Office of the Auditor General reviewing the Attendance Reporting Practices of Physicians at State Hosptials. (See Appendix F for a more extensive listing of audits and assessments conducted in recent years.)

IX. Medicaid Advisory Committee

The federal requirement for a Medicaid Advisory Committee is met in California by the Advisory Committee on Health and Medical Care Services. The present Committee was established in December, 1977, and consists of twelve members, including physicians, other health care providers, consumers, and representatives of other government organizations. All regulatory membership requirements are met, although currently there are several vacancies on the Committee which DHS is seeking to fill. (See Appendix G.1 for specific positions and the current incumbents). The Advisory Committee is staffed by DHS, with the Executive Secretary drawn from the Office of External Affairs.

At present there are three standing subcommittees: Alternative Health Systems, Finance, and Medi-Cal Data. Each of these meets bi-monthly. The full Advisory Committee meets once each month, with the Director of DHS or the Chief Deputy Director for Medical Care Services in attendance.

The current vacancies on the Advisory Committee are the two Medi-Cal recipient slots and the health planning agency representative. DHS staff interviewed indicated that they anticipated these vacancies being filled very soon in spite of past problems in finding consumers willing and able to meet regularly with the

Committee. The transportation and meeting expenses of all Committee members are paid by the State, and recipient representatives can obtain advances if needed. As the assessment team met with various consumer groups, each was asked if they were aware of the Medicaid Advisory Committee and the availability of consumer positions on the Committee. Several individuals were familiar with the Committee, and have in fact been proposed for membership. However, most had not heard of it and thus were directed to the Executive Secretary for further information, updates and possible representation.

The assessment team also met with the Chairman of the Advisory Committee, Dr. Clyde W. Oden. There appeared to be full agreement between DHS staff and Dr. Oden that the Advisory Committee can and does have a significant impact on the Medi-Cal program. The Committee works closely with the DHS Director's Office, but establishes its own agenda and goals, with input from the public through Committee members. All recommendations of the Committee are evaluated by DHS, and a response is always prepared from DHS to the Committee.

Two recent recommendations of the Advisory Committee which have had a major impact on the Medi-Cal program are as follows:

(1) Last year, the Committee recommended that an additional $16 million be spent for out-patient services in calendar 1978, to increase extremely low reimbursement rates and thereby increase the availability of services from Medi-Cal recipients. Approximately, $11.3 million was appropriated by the State Legislature.

(2) In the wake of Proposition 13, the Committee recommended that a special effort be made to monitor the impact of services delivered to welfare recipients. A task force was established for this purpose.

(See Appendix G.2 for a sample log of requests, recommendations and activities of the Advisory Committee).

From discussion with the Chairman of the Committee, it appears that they are working well with DHS, and are satisifed with their impact on the Medi-Cal program. However, there were strong indications of problems with the Department of Finance and their lack of understanding of the problems and impact of their restrictions on the expediture of State funds. For this reason, Dr. Oden indicated it might be helpful to have a representative on the Advisory Committee from DoF.

X. Consumers

In the course of this segment of the assessment, representatives of eleven consumer/welfare recipient organizations were interviewed. Special interest groups included were rural health and welfare rights, Indian health services, welfare mothers, and the disabled. Approximately half of the organizations were from the northern part of California and half from the south. Most groups indicated a general division between the northern and southern organizations, due largely to different needs and problems such as the huge urban area of Los Angeles. However, they also acknowledged that this splinter made them less effective in dealing with the State.

DHS attempts to notify consumer groups as well as providers of legislative proposals and such, and there is an individual in the Office of External Affairs who is working on the organization of permanent ties with consumer groups. However, DHS staff readily admitted that any significant impact of consumers on the Medi-Cal program at this time, apart from their input to the Medicaid Advisory Committee, is really on an ad hoc basis. With respect to consumer participation on the Advisory Committee, both State staff and the Chairman indicated the desirability of having both more welfare recipients on the committee and more general input from them. However, most of the consumer organizations indicated that the only way they could have any real impact or influence would be on a committee composed entirely of consumers; in any other situation they felt they would be out-voted or out-manuevered by providers and/or the government.

Each group interview began with an open-ended discussion of consumer problems, concerns and comments on the Medi-Cal program. Then, if not previously mentioned, the assessment team specifically asked for their input in four areas: (1) transportation; (2) free choice of provider; (3) availability of program manuals, regulations, etc; and (4) potential impact of the Medicaid Advisory Committee. The following sections of the report represent the concerns of the groups interviewed; they do not necessarily reflect the views of the Assessment Team.

A. Major Concerns

The major recurrent issues discussed were as follows:

1. Provider Access - One of the major areas of concern expressed was adequate provider accessability. This problem varies somewhat depending upon locale, and appears to be a particular problem in rural areas. They indicated it is also more prevalent with certain specialities, such as obstetrics, and particularly with the highly specialized fields - for

example, vascular surgeons. Many County Medical Societies will no longer make referrals. Welfare recipients generally felt this problem stems from the lack of adequate reimbursement levels (frequently half the normal charge), the voluminous paperwork involved, reluctance to go through the prior authorization process, lack of physician education on Medi-Cal coverage and procedures, and the lengthy turnaround time for reimbursement (sometimes four to five months). As a result, they indicated some physicians will see Medi-Cal recipients, particularly prior patients, and simply not bill at all. Several groups readily admitted that there is substantial overuse of medical services, but felt this was not limited to Medi-Cal recipients.

2. Coverage - There were a number of complaints regarding the non-coverage of particular services, but these complaints varied widely depending on the individual's particular needs or beliefs - for example, certain allied health professionals; or vitamin therapy for dialysis patients over 21 years of age. There was wide-spread concern with what they view as a lack of preventive health care, including pre-natal care. Recent reductions in the drug formulary were mentioned several times, and all the consumers interviewed were unaware that coverage of any drugs is a State option.

3. Transportation - Lack of adequate transportation under Medi-Cal was another area of major concern to each group interviewed. They indicated that availability varies greatly with locale (though there is some question as to whether the problem is worse in urban areas or in rural), and is generally dependent on county policy. As previously discussed, many counties have totally cut out transportation due to Proposition 13. As a result, needed medical treatment often cannot be obtained. This also ties into the provider access problem where there are no providers close by who will accept Medi-Cal patients.

   The handicapped have special problems in this area, as many are unable to use public transportation. Even with special transportation, such as Dial-a-Ride, few vehicles are equipped to handle all wheelchairs. There are also problems with Dial-a-Ride organizations being unable to cross certain geographic boundaries. Supposedly, most counties will provide transportation to individuals with special needs, but the groups interviewed indicated it is frequently difficult to convince an untrained case worker of the problems a disabled person may have. It was generally agreed by all groups that one of the best ways around the transportation problem is to belong to a health plan or to go to the out-patient department of a county hospital, where buses and specially equipped vans are more likely to be available.

All groups interviewed felt very strongly that the State itself should provide all medically related transportation, and not just for emergency treatment.

4. Eligibility Workers - The groups frequently cited "insensitivity" and lack of knowledge as a problem with eligibility workers in the CWOs, though the blame for this was generally placed at a higher level. Those interviewed commented that the typical eligibility worker is young, with only a high school education and little job training, and poorly paid. In addition, it was claimed that they start out on probation for one year, with no pay increases, and are frequently let go just before the end of their probationary period (to avoid paying higher wages), to be replaced with another new and inexperienced worker. Further problems cited were the heavy workloads of eligibility workers, and their frequent change in assignments.

5. Information Available - Tied in with complaints about the lack of knowledge and time of most eligibility workers, were complaints about lack of information given to and/or available to welfare recipients. The groups interviewed indicated that recipients frequently go without needed services because they are unaware of what benefits are available, or of how to go about obtaining them. And it would appear that those individuals interviewed, because of their leadership and involvement, are probably much better informed than most. Also discussed was the problem of obtaining regulations and program manuals from DHS, and all groups indicated that the DHS distribution policy was much less liberal than that of DSS. Most interviewed were unaware that one Medi-Cal Eligibility Manual plus an on-going subscription can be provided to recipient organizations or legal aid groups at no charge. It was apparent that, under current DHS policies, the needs of at least the smaller, the rural and the geographically wide-spread groups are not being met.

6. Consumer Input - The general feeling expressed was that consumers have no input into the Medi-Cal program. As mentioned in the previous section, most welfare recipients have been unaware of the Medicaid Advisory Committee, though several of those interviewed have been proposed for membership. Some felt the composition of the committee should be two-thirds consumers and that the Chairperson should not be a provider. However, most felt their only real impact would be through a committee composed entirely of consumers.

7. Affirmative Action - Several complaints were voiced regarding the lack of enforcement of affirmative action regulations for recipients. Specifically mentioned was one affirmative action group with a backlog of 800,000 cases of discrimination awaiting investigation.

8. Hospitals - There were several instances discussed of inappropriate hospital actions, such as billing patients directly and, when no payment is forthcoming, turning the account over to a collection agency, with subsequent damage to a recipient's credit rating. Another problem mentioned was that of hospital emergency rooms taking two medi-labels after midnight, apparently to deter patients from coming in so late. DHS staff volunteered to look into each of these problems.

9. Other - Other problems discussed were specific to El Dorado County and the South Lake Tahoe area, but may well occur elsewhere. These include the long time period of 45 days from the date of application which it takes to get a Medi-Cal card, and the counties refusal to issue emergency cards. El Dorado County seems also to have particular problems with provider access, even to the extent that a nurse practitioner who will see Medi-Cal patients cannot find a physician to serve as her required consultant. This particular area has also experienced problems in that it apparently qualifies as neither an urban nor a rural area.

XI. Findings and Recommendations

As one of the two largest states in this country in terms of population and consequent size of the Medicaid program, California is faced with many problems which are either unique or of much greater magnitude than found elsewhere. As such, California has already solved or is solving many problems and conflicts which are just now being discovered by other states. In addition, the broad scope of eligibility and benefits under Medi-Cal, due in large part to the historically liberal attitude of Californians toward social programs, further increases the potential for problems in many areas. All this must be recognized and considered in evaluating the Medi-Cal program as a whole, and in particular its management and administration.

In the course of this segment of the assessment, a number of areas were reviewed in which no major problems were encountered and, in fact, numerous policies and procedures were noted which appear to be particularly effective. Examples of such include the current open and receptive relationship of the Director of DHS with the Legislature, as well as with provider organizations and consumer groups; the impact achieved by the Medicaid Advisory Committee and its positive relationship with DHS; the daily on-site review of TAR extensions in acute hospitals by field office nurse consultants, and the home visits by nurses and social workers to ascertain needs for medical equipment, including repairs and possible alternatives; the positive and productive relationships established between DHS Field Representatives and the CWOs; and the pre-application procedures established in many of the larger CWOs which save considerable time for both eligibility workers and recipients.

Listed below are those areas of the program or its administration in which were found problems of sufficient magnitude, or effect on Medi-Cal recipients, that State action is recommended to correct or remedy the situation. In the previous sections of this report indicated in parentheses by each item, a more specific discussion of the problem and its background may be found.

1. Single State Agency Requirement (Sections II.B; V)

   Findings

   Under present operating procedures the Department of Finance exerts considerable control over the Department of Health Services. DoF has virtual veto power over every regulation processed by DHS, as well as every Medi-Cal budget request. However, 45 CFR 205.100(b) requires that the "State agency will not delegate to other than its own officials its authority for exercising administrative discretion in the administration or supervision of the plan including the issuance of policies, rules, and regulations on program matters". This regulation further requires that if "any rules and regulations or decisions of the single State agency are subject to review, clearance, or other action by other offices or agencies of the State government, the requisite authority of the single State agency will not be impaired".

It is recognized that, under State law, DoF must necessarily enforce the total budget limitations imposed on each State department, and that the State's Budget Act mandates DoF review of DHS regulations and certification of the availability of funds before regulations can go to public hearings. And for these reasons, it is very important for DoF to be aware of and familiar with the operations and the problems of the Medi-cal program. However,DoF's present involvement in the day-to-day management of the Medi-Cal program appears to violate federal single State agency requirements.

Recommendations

The State should take whatever steps are necessary to place day-to-day control of the Medi-Cal program solely in the hands of DHS, as required under 45 CFR 205.100. In addition, however, because of DoF's mandated involvement in the Medi-Cal budget, it is recommended that DoF staff become more knowledgeable about and involved in the program through inclusion in DHS staff discussions.

2. Fragmentation of Authority and Control (Section II)

Findings

Because of the extreme fragmentation of authority and control within the Medi-Cal program as a whole, and particularly with reference to the Department of Finance, the Department of Social Services and the numerous segments of DHS dealing with the program, a substantial problem is created in coordination and uniformity of understanding among State employees, and, even more so, for CWO staff and others dealing most closely with Medi-Cal recipients. This situation creates the problems most frequently mentioned by staff of the field offices and CWOs, as well as in State headquarters. With no single, central location where all components of the program are integrated, there is confusion as to whom to talk with regarding specific problems and policy interpretations, and as to who has authority to direct or give final answers. In spite of numerous reorganizations, this is not a new situation; the problems of a fragmented administration were noted in the 1975 assessment of the Medi-Cal program.

Recommendations

It is recommended that the State review the overall organization and administrative authority of those administering the Medi-Cal program, with consideration toward re-aligning functions to provide better coordination for field offices and CWO staff. The consolidation of authority for all eligibility determinatins within the Department of Social Services should be explored. Finally, a formal, effective system of coordination and exchange of information is needed between DHS and DSS; between DHS headquarters and the field; and among the Medi-Cal Field Offices, the CWOs and the SSA DOs.

3. Staffing (Sections II.B.6 and C; III; IV.C; X, Item 4)

Findings

Throughout this assessment, the cutbacks in staff allocations and the many unfilled vacancies resulting from Proposition 13 have been a major, perhaps the major, problem encountered. Staff shortages have affected all program areas and all organizational areas. Specific vacancies encountered which have a current detrimental effect on the program include physicians and a full-time Regulations and Compliance Coordinator in DHS headquarters, clericals and social workers in Medi-Cal field offices, and eligibility workers in CWOs. It is in the CWOs where the results of such shortages are most directly felt by the Medi-Cal recipient, when eligibility workers have insufficient time and training to inform the consumer of his/her benefits and how to obtain them. Although the fiscal problems resulting from the passage of Proposition 13 are acknowledged, as well as additional problems involving the timeliness of filling vacancies due in part to the policies and procedures of the State Personnel Board, it is felt that the Medi-Cal program cannot function at acceptable levels under the current staff shortages.

Recommendations

It is recommended that the State review its current allocation of resources and work toward increasing the number of physicians on DHS headquarters staff, with consideration given to more competitive salaries and stronger recruitment efforts; that a full-time Regulations and Compliance Coordinator be appointed, to report directly to the Chief Deputy Director for Medical Care Services; and that the major vacancies for clerical staff and social workers in Medi-Cal Field Offices be filled immediately. It is further recommended that procedures within the State Personnel Board be reviewed toward decreasing the usual time required to establish a list of eligibiles for vacant positions.

4. Written Communications (Sections II.B and C; IV.C; X, Item 5)

Findings

The problems encountered in field offices, and particularly in CWOs, due to the number of different areas from which they receive instructions and guidelines are further exacerbated by the lack of consistency and clarity in much of the written material on which they are expected to rely. DHS and DSS regulations and guidelines are occasionally incompatible, indicating there is insufficient communication among headquarters staff. Other problems encountered by field offices and CWOs with respect to written material provided by DHS included the timeliness of receipt, the need for a system to ascertain that all relevant material is received, and insufficient material, in both quantity and quality, for training CWO employees and informing recipients about Medi-Cal. Recipients also complained of their lack of access to manuals and regulations, and providers complain that there is no Provider Manual, the MIO-prepared Medi-Cal Bulletins being considered insufficient and too difficult to use as a reference source.

Recommendations

Care should be taken to assure that there is appropriate coordination with all program areas, including AFDC, prior to issuance of any regulations or instructions, including any necessary legal interpretation. All DHS required forms, and the instructions for completing such, should be provided to field offices and CWOs in sufficient time and quantity for proper completion, and all issuances to field offices and CWOs should be numbered to assure receipt of all appropriate material. There should be some assurance that Medi-Cal Bulletins are received in field offices and CWOs no later than they are received by providers, and it is recommended that, as DHS takes over the provider relations function with the change in fiscal intermediaries, a Provider Relations Manual be established.

It is further recommended that training materials for CWO staff, and SSA DOs, be reviewed to assure that it is specific enough and available in sufficient quantities to meet their needs; and that handouts and brochures in sufficient quantity and specificity be made available to recipients through all CWOs and SSA DOs. Finally, Medi-Cal recipients should be informed that manuals and regulations are available for their use in all CWOs and in many public libraries.

5. TAR System (Sections II.B.5 and C.1)

Findings

The lack of uniform written criteria sets for TAR approvals and denials is another problem area which was noted in 1975 and which still exists. This results in inconsistencies from one office to another, and even from one consultant to another. In addition, providers do not have access to those guidelines which are used by consultants, a situation which leads to inappropriate requests and unnecessary complaints regarding denials.

Recommendations

It is recommended that the twenty sets of criteria currently under development be completed and issued to the field office medical consultants as soon as possible, and that work begin immediately on establishing additional sets of criteria. It is further recommended that current policy statements and guidelines regarding TARs, as well as criteria sets as they are established, be supplied to providers. Finally, some source of information, preferably for telephone calls, should be established to provide information to providers and recipients regarding the scope of Medi-Cal benefits.

6. Provider Access (Section X, Item 1)

Findings

The problems of access to providers, particularly physicians, vary greatly by geographic area and by physician specialty. Welfare recipients interviewed indicated that they felt the major causes of physician refusal to accept Medi-Cal patients were low reimbursement rates (also noted in 1975), slow turnaround in payment, too much paperwork, lack of physician knowledge of coverage and claims procedures, and reluctance to go through the prior authorization system.

Recommendations

It is recommended that the State and Federal governments work together to determine the extent of the provider access problem, and explore possible solutions. The current fee schedule should be reviewed, as well as procedures for processing claims and for providing guidance to physicians regarding coverage and proper submission of claims.

7. Supplemental Appropriations (Section V)

Findings

Annual budget requests submitted by DHS are invariably reduced below actual expenditure needs by the Department of Finance (DoF) and the Governor. Then, due to the subsequent need for a supplemental appropriation from the Legislature, and while this is being processed, there is a period each year when payments to providers are stopped due to insufficient Medi-Cal funds, and thus services to recipients are curtailed.

Recommendations

It is recommended that the State take whatever measures necessary to approve a more realistic Medi-Cal budget so as to avoid cost over-runs and the subsequent need for a supplemental appropriation.

8. Field Office Management Reviews (Section VIII)

Findings

The management reviews of the Medi-Cal Field Offices, conducted by the Benefits Branch of the Medical Care Standards Division, are currently running several years behind schedule.

Recommendation

It is recommended that the schedule for management reviews of Medi-Cal Field Offices be re-established on an annual basis.

9. Medi-Cal Cards (Section II.C.2)

Findings

Problems with both medi-labels and proof-of-eligibility labels have existed for years, and many complaints were voiced by both staff and recipients in the course of this assessment. The primary use of these "sticky labels" to determine eligibility was supposed to be replaced by use of an automated recipient eligibility file with implementation of the new FI, Computer Sciences Corporation, but it is now understood that a change order to the new contract is being contemplated, under which sticky labels would be required.

Recommendations

It is recommended that DHS again review the required use of sticky labels, with particular consideration given to use of the Recipient Eligibility History File as primary proof of eligibility.

10. Transportation (Sections VII. A; X, Item 3)

Findings

It seems apparent that some DHS staff have misinterpretated federal regulations regarding requirements for the provision of medically necessary transportation. Federal regulations apply not only to emergency transportation, or that requiring special medical equipment, but also to transportation necessary for recipients to obtain any needed medical services. In addition, DHS can no longer rely on regular transportation needs being met through current AFDC and SSI cash grants, nor on the counties providing funds for transportation under "recurring special needs" - particularly in light of the shortages of county funds due to Proposition 13. Changes must be implemented to eliminate the current problems of (1) counties not having available funds for recurring special needs; (2) an unreasonable limit on the amount allowed for recurring special needs; (3) no provisions for recurring special needs for the Medically Needy Only group; (4) a nonspecific, inadequate amount for transportation being included in the cash grants of categorically needy recipients, and (5) lack of clarity as to what need factors are taken into account in setting maintenance need amounts.

Recommendation

It is recommended that the State take over fiscal responsibility and make specific payments for all transportation needs.

APPENDICES

A. Organization Charts

  1. Health and Welfare Agency
  2. Department of Health Services (DHS)
  3. Medi-Cal Division
  4. Medical Care Standards Division
  5. Alternative Health Systems Division

B. Written Communications Provided to:

  1. Medi-Cal Field Offices
  2. County Welfare Offices

C. Samples of Forms and Handouts from County Welfare Offices

  1. Information Sheet, used in San Diego CWO
  2. Screening Sheet, used in San Diego CWO
  3. Emergency Medical Referral, used by SSA DO's to San Bernardino CWO
  4. Interview Appointment Instructions, given to San Diego CWO applicants
  5. Important Information About Your Medi-Cal Care and Benefits, handout used by San Diego CWO
  6. Medi-Cal booklet, given out in CWOs and SSA DOs

D. Performance Appraisal Form

E. DHS Contract Procedures

F. Audits and Assessments

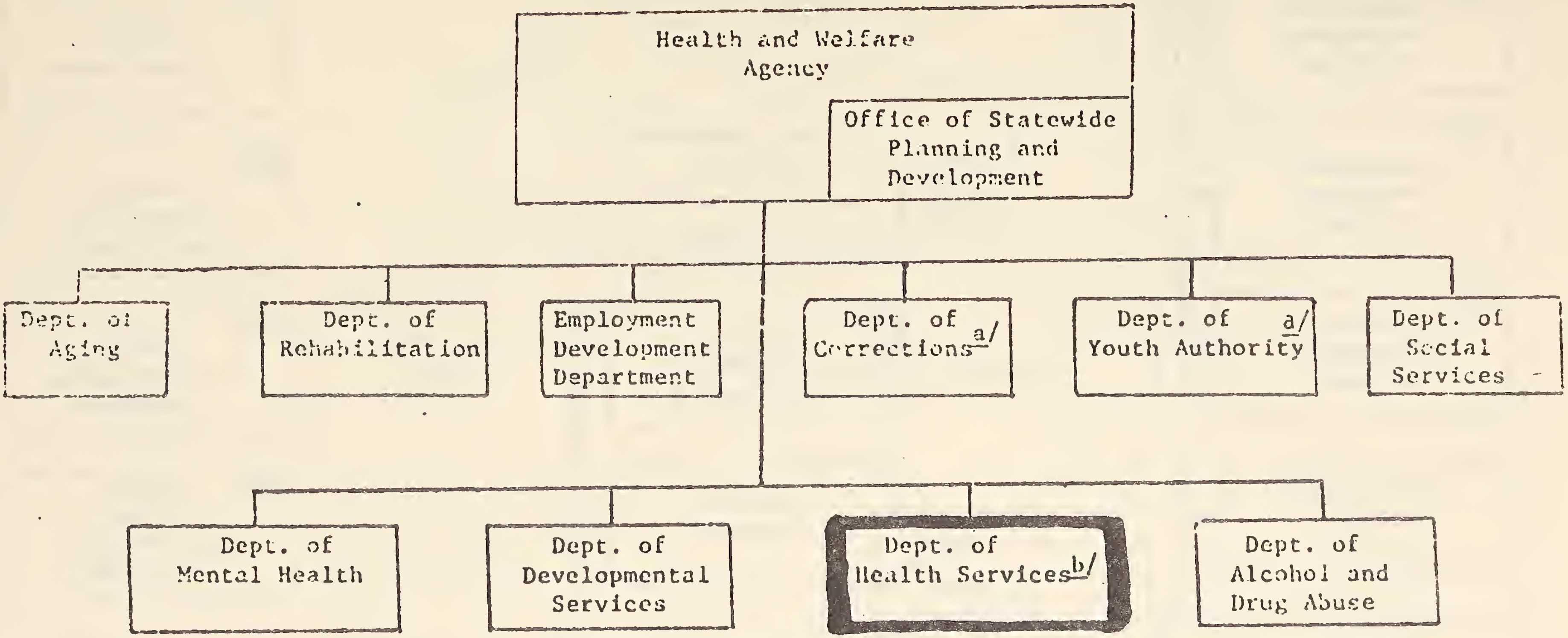
G. Medicaid Advisory Committee

  1. Membership
     a. Full Committee
     b. Subcommittees
     c. Interest Group Representation

  2. Log of Requests and Recommendations

Appendix A.1

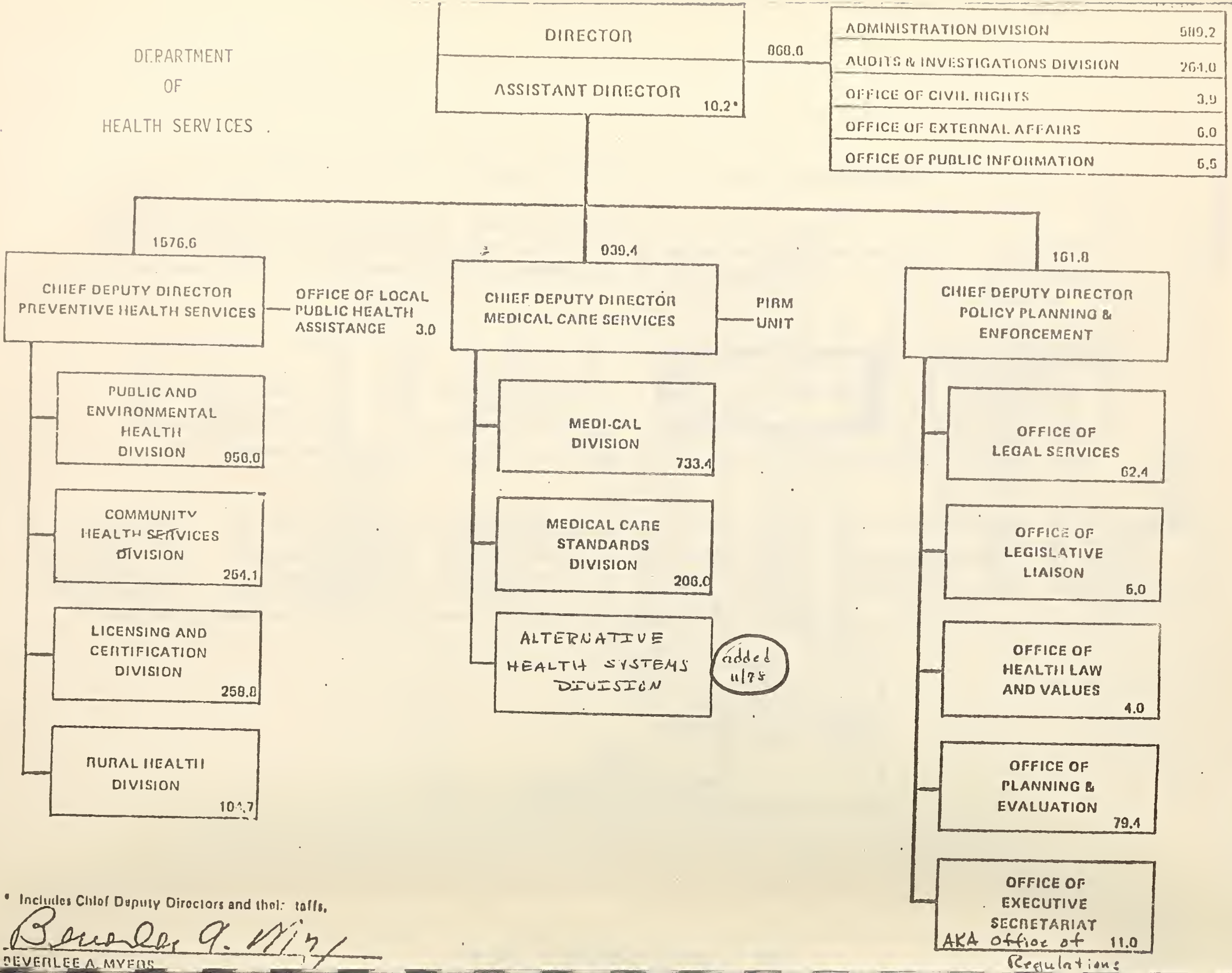
ORGANIZATION
SB 363 -- EFFECTIVE JULY 1, 1978


Health and Welfare Agency
Office of Statewide Planning and Development
Dept. of Aging
Dept. of Rehabilitation
Employment Development Department
Dept. of Corrections a/
Dept. of Youth Authority a/
Dept. of Social Services
Dept. of Mental Health
Dept. of Developmental Services
Dept. of Health Services b/
Dept. of Alcohol and Drug Abuse

[a] SB 363 provides that the Governor shall submit to the Legislature by January 31, 1979, a reorganization plan which would remove the Departments of Corrections and Youth Authority from the Health and Welfare Agency by July 1, 1979.

[b] Includes public health, Medi-Cal, and health facilities licensing functions.

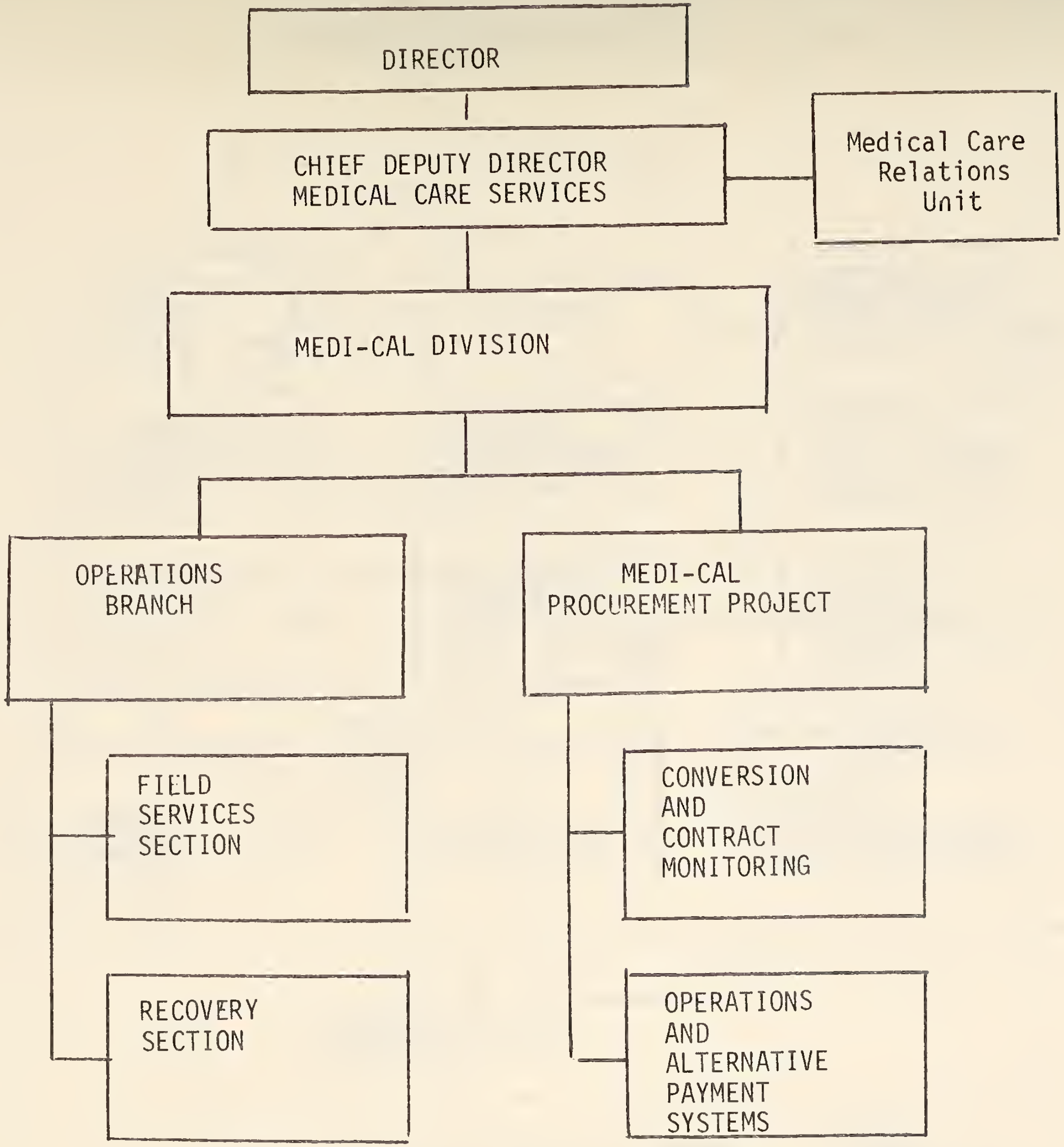
Appendix A.2


DEPARTMENT
OF
HEALTH SERVICES .
DIRECTOR
ASSISTANT DIRECTOR 10.2*
868.0
ADMINISTRATION DIVISION 589.2
AUDITS & INVESTIGATIONS DIVISION 264.0
OFFICE OF CIVIL RIGHTS 3.9
OFFICE OF EXTERNAL AFFAIRS 6.0
OFFICE OF PUBLIC INFORMATION 6.5
1576.6
CHIEF DEPUTY DIRECTOR PREVENTIVE HEALTH SERVICES
OFFICE OF LOCAL PUBLIC HEALTH ASSISTANCE 3.0
PUBLIC AND ENVIRONMENTAL HEALTH DIVISION 956.0
COMMUNITY HEALTH SERVICES DIVISION 254.1
LICENSING AND CERTIFICATION DIVISION 258.8
RURAL HEALTH DIVISION 104.7
939.4
CHIEF DEPUTY DIRECTOR MEDICAL CARE SERVICES
PIRM UNIT
MEDI-CAL DIVISION 733.4
MEDICAL CARE STANDARDS DIVISION 206.0
ALTERNATIVE HEALTH SYSTEMS DIVISION
added 11/78
161.8
CHIEF DEPUTY DIRECTOR POLICY PLANNING & ENFORCEMENT
OFFICE OF LEGAL SERVICES 62.4
OFFICE OF LEGISLATIVE LIAISON 6.0
OFFICE OF HEALTH LAW AND VALUES 4.0
OFFICE OF PLANNING & EVALUATION 79.4
OFFICE OF EXECUTIVE SECRETARIAT 11.0
AKA Office of Regulations

* Includes Chief Deputy Directors and their staffs.

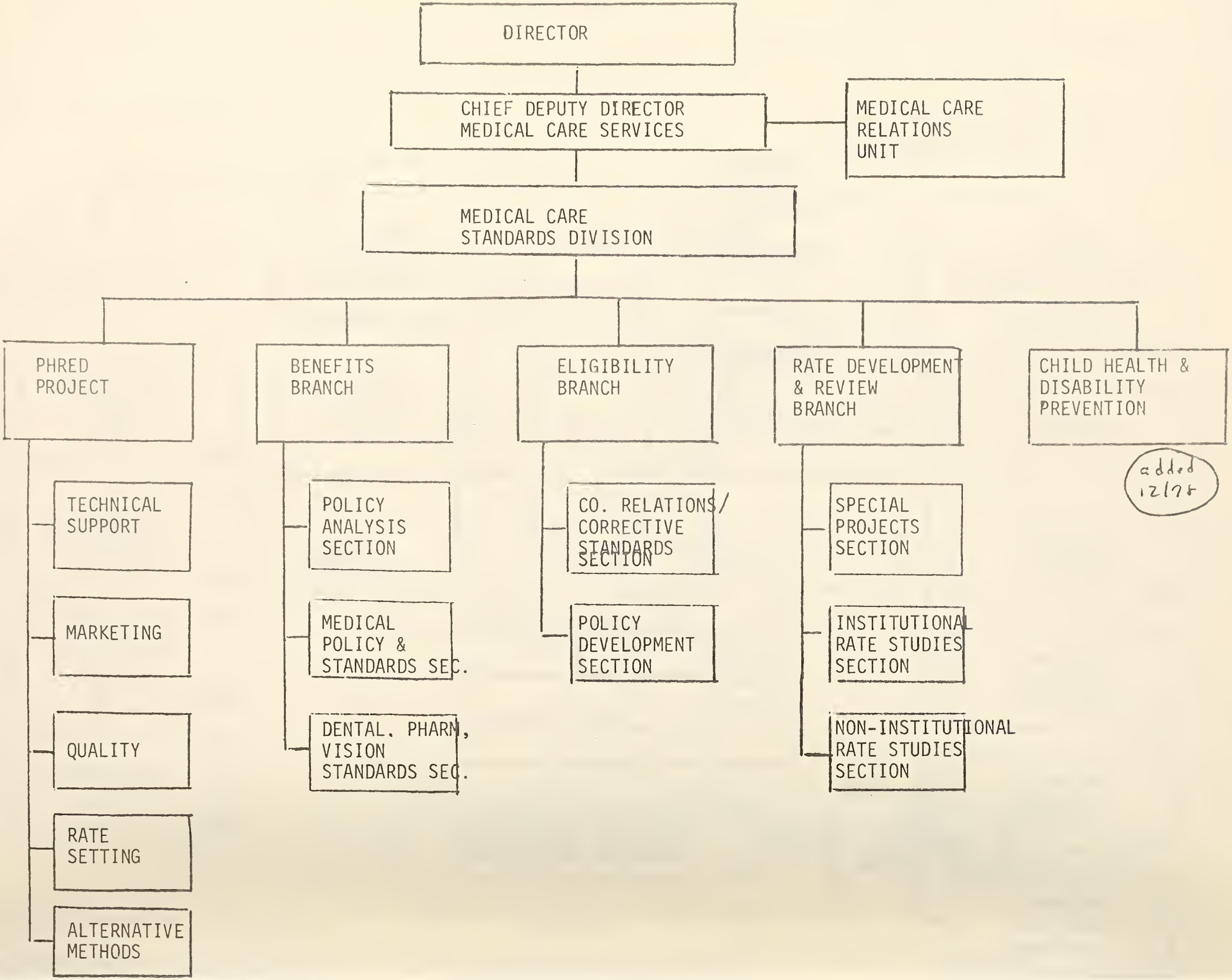
BEVERLEE A. MYERS

DEPARTMENT OF HEALTH SERVICES


DIRECTOR
CHIEF DEPUTY DIRECTOR MEDICAL CARE SERVICES
Medical Care Relations Unit
MEDI-CAL DIVISION
OPERATIONS BRANCH
MEDI-CAL PROCUREMENT PROJECT
FIELD SERVICES SECTION
RECOVERY SECTION
CONVERSION AND CONTRACT MONITORING
OPERATIONS AND ALTERNATIVE PAYMENT SYSTEMS

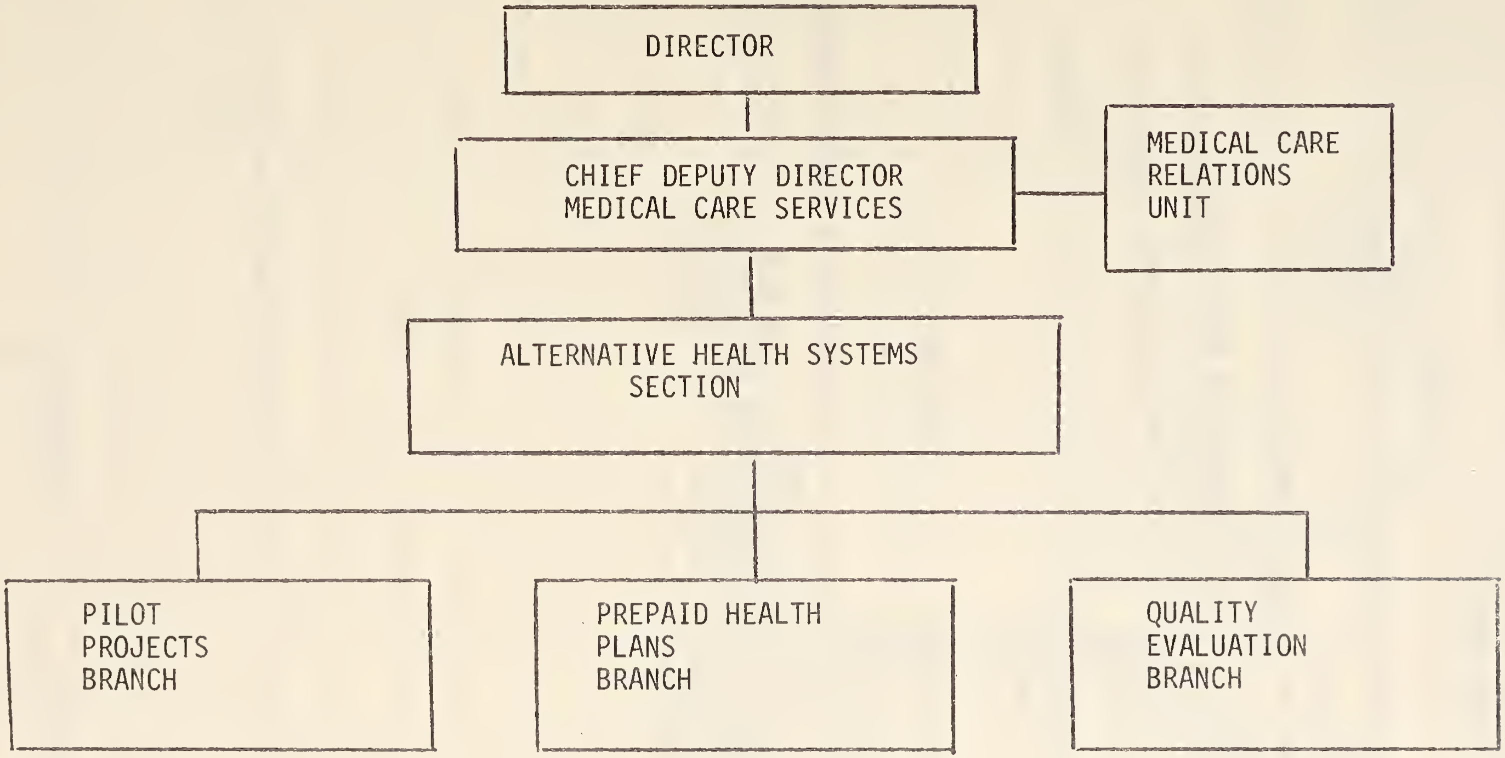
Appendix A.4

DEPARTMENT OF HEALTH SERVICES


DIRECTOR
CHIEF DEPUTY DIRECTOR MEDICAL CARE SERVICES
MEDICAL CARE RELATIONS UNIT
MEDICAL CARE STANDARDS DIVISION
PHRED PROJECT
TECHNICAL SUPPORT
MARKETING
QUALITY
RATE SETTING
ALTERNATIVE METHODS
BENEFITS BRANCH
POLICY ANALYSIS SECTION
MEDICAL POLICY & STANDARDS SEC.
DENTAL. PHARM, VISION STANDARDS SEC.
ELIGIBILITY BRANCH
CO. RELATIONS/ CORRECTIVE STANDARDS SECTION
POLICY DEVELOPMENT SECTION
RATE DEVELOPMENT & REVIEW BRANCH
SPECIAL PROJECTS SECTION
INSTITUTIONAL RATE STUDIES SECTION
NON-INSTITUTIONAL RATE STUDIES SECTION
CHILD HEALTH & DISABILITY PREVENTION
added 12/78

Appendix A.5

DEPARTMENT OF HEALTH SERVICES


DIRECTOR
CHIEF DEPUTY DIRECTOR MEDICAL CARE SERVICES
MEDICAL CARE RELATIONS UNIT
ALTERNATIVE HEALTH SYSTEMS SECTION
PILOT PROJECTS BRANCH
PREPAID HEALTH PLANS BRANCH
QUALITY EVALUATION BRANCH

Written Communications

Listed below are the documents and written communications regarding Medi-Cal which are provided to the Field Office and County Welfare Offices on a regular basis. Those items followed by "#" are numbered in sequence so that the recipient organization can determine if an issuance has been missed.

1. Written Communications to Medi-Cal Field Offices

- Title 22 and updates
- Field Instruction Notices, from DHS (#)
- Health Administrators Memos
- Policy Statements, from DHS Benefits Branch (#)
- Medical Consultant Guidelines, prepared by the DHS Field Services Section for the Benefits Branch
- Intermediary Letters, prepared by the DHS FI section for MIO (#)
- Medi-Cal Bulletins, prepared by MIO for Providers (indexed every 6-12 months)

2. Written Communications to County Welfare Offices

- Title 22 and updates
- Medicaid Eligibility Manual, with regulations and procedures, from DHS Eligibility Branch
- Eligibility and Assistance Manual, from DSS
- All County Memos, from DHS and DSS (#)
- All County Information Notices, from DSS (#)
- Medi-Cal Bulletins

INFORMATION SHEET

APPENDIX C.1

SE PRINT

NAME: (Last, First, Middle Initial)	ALIASES:	TELEPHONE NUMBER
HUSBAND'S OR WIFE'S NAME: (Last, First, Middle Initial)		
ADDRESS: (Number, Street, City, State, Zip Code)		
TAL STATUS: (Check One) Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed	WOMAN'S MAIDEN NAME:	

T ALL PERSONS FOR WHOM YOU ARE REQUESTING AID: (Include yourself and any unborn) — FOR COUNTY USE

NAME st, First, Middle Int.)	SOCIAL SECURITY NUMBER	BIRTH DATE (mo/day/yr)	COMPLETE FOR CHILDREN ONLY PARENT'S NAME	CASE NUMBER
's	- -	/ /	(MO - Mother) (FA - Father)	
an's	- -	/ /	(Last, First, Middle)	
arried Children	- -	/ /	MO FA	
			MO FA	
			MO FA	
			MO FA	
			MO FA	

ALL OTHER PERSONS LIVING IN THE HOME (Friends, Relatives) — FOR COUNTY USE

NAME st, First, Middle Int.)	SOCIAL SECURITY NUMBER	BIRTH DATE (mo/day/yr)	SEX (M/F)	RELATIONSHIP TO CHILDREN	CASE NUMBER
	- -	/ /			
	- -	/ /			
	- -	/ /			
	- -	/ /			
	- -	/ /			
	- -	/ /			

FOR COUNTY USE ONLY

FOR COUNTY USE ONLY

CASE NAME	ALIASES	CASE NO.	DIST. #	APP DATE

ADDRESS	TELEPHONE

07-108 DPW (6-78)

FOR COUNTY USE ONLY FOR COUNTY USE ONLY

Previous Addresses	NAME	PARENTS OF MAN	ADDRESS	TELEPH
	FA.			
	MO.			
		PARENTS OF WOMAN		
	FA.			
	MO.			

	NAME	ADDRESS	KINSHIP	TELEPH
THER				
EL.				

ILITARY RECORD. NAME	KIN	C. OR ☐ SERIAL # ☐	BRANCH	RANK	DATE ENTERED	DATE DISCHARGED	TYPE DISCH

ENT MARRIAGE DATE: PLACE:

VIOUS MARRIAGES	NAME	DATE	ADDRESS	DATE OF DIV DEAT

EMPLOYMENT HISTORY					INSTITUTION/ AID TYPE
#	EMPLOYER	ADDRESS	FROM	TO	

SCREENING SHEET

APPENDIX C.2

AME: ______________________________ DATE: ____________________

SWER ALL OF THE FOLLOWING QUESTIONS!	YES	NO	FOR COUNTY USE ONLY
DO YOU HAVE ANY CHILDREN (UNDER 21 YEARS OLD) IN THE HOME?	☐	☐	
ARE YOU PREGNANT?	☐	☐	
IS EITHER PARENT OF THE CHILDREN:			
A. Deceased?	☐	☐	
B. Mentally or Physically Disabled?	☐	☐	
C. Absent?	☐	☐	
D. Employed?	☐	☐	
IS THERE A STEP-PARENT IN THE HOME?	☐	☐	
ARE ANY OF YOUR CHILDREN UNDER 6 YEARS OLD?	☐	☐	
ARE ANY OF YOUR CHILDREN 16 YEARS OR OLDER?	☐	☐	
IF YES: ARE THEY ATTENDING SCHOOL OR IN A TRAINING PROGRAM?	☐	☐	
ARE ALL PERSONS FOR WHOM YOU ARE APPLYING U. S. CITIZENS?	☐	☐	
DO ALL MEMBERS OF YOUR FAMILY HAVE SOCIAL SECURITY NUMBERS?	☐	☐	
DOES ANYONE IN THE HOUSEHOLD RECEIVE MONEY FROM:			
A. Social Security/Veterans Benefits?	☐	☐	
B. Employment?	☐	☐	
C. Unemployment/Disability Benefits?	☐	☐	
D. Strike Benefits?	☐	☐	
E. Cash Gifts, Awards/Prizes, Scholarships, Educational Loans?	☐	☐	
F. Foster Care Payments?	☐	☐	
G. Annuities and Pensions (Retirement)?	☐	☐	
H. Child Support and/or Alimony?	☐	☐	
I. Persons Living in the Home and Paying Room and Board?	☐	☐	
J. SSI/SSP Benefits (Gold Check from Social Security)?	☐	☐	
K. Vacation Pay?	☐	☐	
L. Welfare Assistance?	☐	☐	
M. Other?	☐	☐	
DO YOU OR ANY PERSONS FOR WHOM YOU ARE APPLYING HAVE:			
A. Checking Accounts?	☐	☐	
B. Savings Accounts?	☐	☐	
C. Stocks and/or Bonds?	☐	☐	
D. Trust Funds?	☐	☐	
E. Real Property (House, Land, etc.)?	☐	☐	
F. Personal Property (Campers, Boats, etc.)?	☐	☐	
G. Motor Vehicles?	☐	☐	
H. Life Insurance Policies?	☐	☐	
HAVE YOU SOLD OR GIVEN AWAY ANY PROPERTY IN THE PAST TWO YEARS?	☐	☐	

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(CONTINUE ON THE BACK)

	YES	NO
12. DO YOU WISH INFORMATION OF FAMILY PLANNING?........................	☐	☐
13. DO YOU WISH TO TALK TO A SOCIAL WORKER?................................	☐	☐
14. A. HOW MUCH RENT DO YOU PAY? $__________ IS IT PAID THIS MONTH?......	☐	☐
B. HOW MUCH DO YOU PAY FOR UTILITIES? $__________ ARE THEY PAID?......	☐	☐
C. AMOUNT OF CASH ON HAND $______________		
D. ANY IMMEDIATE MEDICAL PROBLEMS?................................	☐	☐
E. NUMBER OF DAYS SUPPLY OF FOOD IN HOME # ________		

FOR COUNTY USE ONL

FP3 & 3A GIVEN ☐ YE

REFERRAL MADE

☐ YES ☐ NO

CHDP BROCHURE GIVEN

☐ YES

FOR COUNTY USE ONLY FOR COUNTY USE ONLY

COMMENTS: ____

____

____

____

____

HOW TO COMPLETE THE STATEMENT OF FACTS FOR MEDI-CAL

Many of the questions on this form are difficult to answer because of the way the questions are asked. Because this form is also used by families applying for Medi-Cal, many of the questions begin with the words, "Does any family member..." or "Are all family members..." or "Does anyone in the family..."

If you have never been married, or are now separated, divorced or widowed, and you are applying for Medi-Cal for only yourself, think of the word "you" where you see reference to "family members". Answer all of the questions, but only as they apply to you. If you and your spouse are applying, answer the questions as they apply to the two of you.

If you are applying on behalf of someone else, answer the questions the way that person would answer them.

In addition, Item #27 (Page 8 of 9) does not apply to you if you have no minor children or if you do not live with your minor children and are not applying for them. If this is the case, mark "N/A" for Item #27.

EMERGENCY MEDICAL REFERRAL

TO: San Bernardino Department of Public Social Services

FROM: Social Security Administration, ______________________________
(City)

NAME ______________________ SSN ____________________________

ADDRESS ______________________ DOB ____________________________

______________________ PHONE # _________________________

☐ The above named person has applied for SSI-SSP as:
(Circle one) aged, blind, disabled as of ________________(date).
No award has been made as of this date. This person is in need of
a MediCal card.

☐ The above named person has been awarded SSI-SSP effective
____________________(date). This person has not received
a MediCal card for _____________(month) and is in need of
a card.

☐ The above named person has been denied SSI-SSP.

☐ Check is issued by: (Circle one) regular system, one-time-pay,
force pay.

☐ The above named person was terminated from SSI-SSP as of
___________________(date) and wishes to file for MediCal
card for the month of _________________.

☐ Termination was due to a change in living arrangements,
income, or other non-disability reasons.

☐ Termination was because disability/blindness period ended.

Social Security employee signature: _________________________

Phone: _______________ Date: _______________ Unit: _______

DO-163 (6/78)

COUNTY OF SAN DIEGO

INTERVIEW APPOINTMENT INSTRUCTIONS

APPENDIX C.4

AME OF APPLICANT ____ APPOINTMENT DATE: ____

AME OF PERSON APPLYING ON BEHALF OF APPLICANT ____ APPOINTMENT TIME: ____

IMPORTANT: In order to serve each person scheduled for the day, it is very important that you be on time and have all your papers completed.

ANY PERSON MORE THAN 15 MINUTES LATE WILL BE RESCHEDULED FOR A LATER DATE

- Please telephone ____ if you must change your appointment.
- Show this form to the receptionist when you return for your scheduled appointment.

YOU MUST BRING ALL THE ITEMS CHECKED BELOW TO YOUR NEXT INTERVIEW:

COMPLETED FORMS:

☐ Statement of Facts for Medi-Cal
☐ Supplement to Statement of Facts (for retroactive benefits)
☐ Medical History and Disability Report
☐ Application for Food Stamps
☐ Stepparent Questionnaire
☐ Work Registration Form (for Food Stamps)

PROOF OF INCOME:

☐ Pay Stubs for ____
☐ Social Security Award Letter
☐ VA Benefit Award Letter
☐ Unemployment Benefit Booklet
☐ ____
☐ ____

OTHER NECESSARY EVIDENCE:

☐ Statement or completed Form CA 341 from (Physician) (Clinical Laboratory) verifying ____
____
☐ INS FORM (I-151) (I-94)
☐ ____
☐ ____
☐ ____

INFORMATION ABOUT YOUR PROPERTY:

☐ Escrow Papers
☐ Assessed Value For ____
☐ Property Tax and Mortgage Balance for ____

OTHER INFORMATION:

☐ ____
☐ ____
☐ ____
☐ ____
☐ ____
☐ ____

*SEE REVERSE FOR INSTRUCTIONS FOR COMPLETING THE STATEMENT OF FACTS FOR MEDI-CAL.

07-114 DPW(8-78)

State of California—Health and Welfare Agency Appendix C.5 Department of Health

IMPORTANT INFORMATION ABOUT YOUR MEDI-CAL CARD AND BENEFITS

You and the members of your family for whom you applied will receive a Medi-Cal card each month you are eligible for Medi-Cal.

If you have a share of cost (only some persons on Medi-Cal have this), you have to pay, or agree to pay part of your income toward your medical expenses before Medi-Cal can pay the rest. You'll receive a card after you have met your share of cost. Your county worker will explain how this works.

YOUR MEDI-CAL CARD

Medi-Cal benefits are paid for with two kinds of labels from the Medi-Cal card. The two kinds of labels are MEDI and POE (Proof of Eligibility).

MEDI labels are used for the following Medi-Cal benefits:

Chiropractic services
Eye Care (Optometric services)
Foot Care (Podiatry services)
Hearing Care (Audiology services)
Physical, Occupational or Speech Therapy
Psychological services

These services are limited to two per month, *however,* providers of podiatry services and physical therapy may get approval from the State to provide more. You will only receive two MEDI labels on each card and your county welfare department cannot give you more.

POE (Proof of Eligibility) labels are used for services on the following list. There is no automatic limit on the amount of services available with them but many of these services have to be approved by Medi-Cal consultants before they are given. The doctor or other provider has to contact a consultant in the State Medi-Cal office for this approval. The county department can give you more POE labels if you run out.

Allergy
Artificial limbs and braces
Assistive devices, durable medical equipment and medical supplies
Blood and blood derivatives
Dental services
Drug services
Eyeglasses, artificial eyes and eye appliances
Family Planning services
Health Screening for persons under 21
Hearing aids
Home health agency services
Inpatient hospital services
Intermediate care facility services
Kidney treatment (Hemodialysis services)
Laboratory, X-ray and radiation treatment
Medical transportation
Nursing home (skilled nursing facility services)
Physician services (most physician office visits do not require prior approval)
Psychiatry
Rehabilitation services (physical, occupational, speech therapy and audiology) .

POE labels may also be used for Physical Therapy, and podiatry services when you run out of MEDI labels, *if* the State Medi-Cal consultant gives approval for the service.

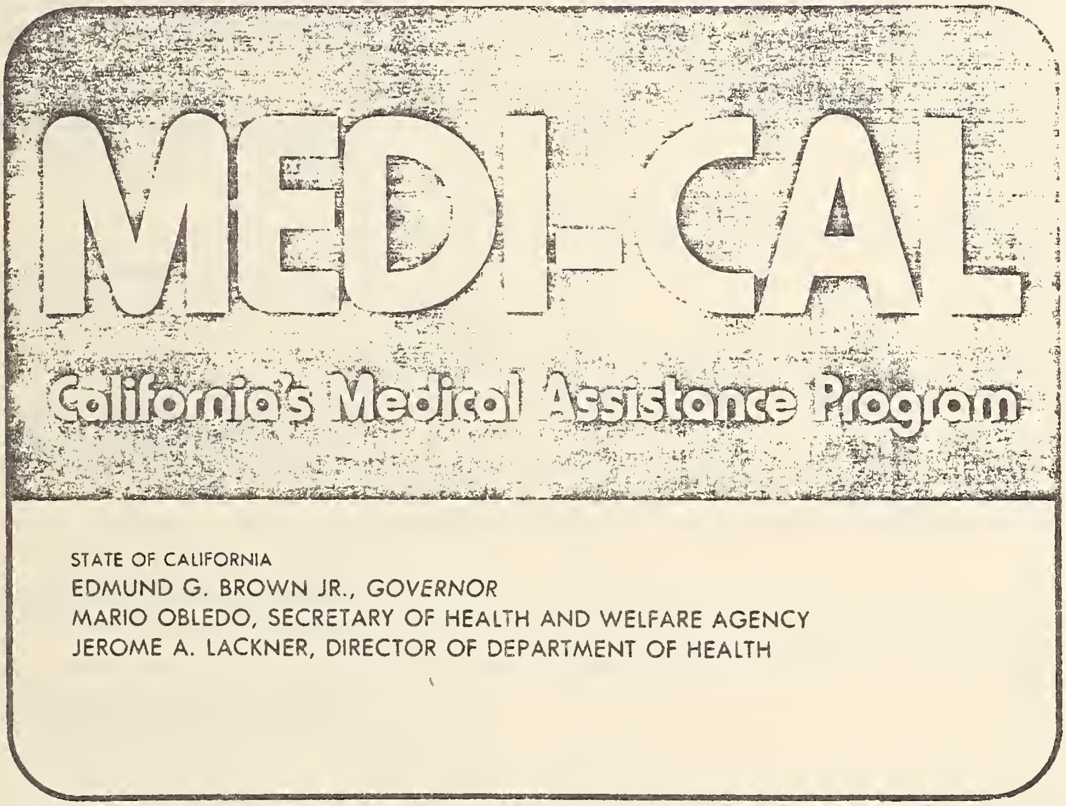
You should always carry your Medi-Cal card with you. If you need emergency services at any time, the person who gives you the service will need one of the labels from your card. If you do not have the card with you, you will have to give the correct label later.

You should retain your Medi-Cal card for at least two months to make sure that your providers have the labels they need. If you run out of POE labels the provider may photocopy your card and use the photocopy in the place of a POE label.

After you have given a label to a provider, he/she uses it to obtain payment from the State of California. Each label is good for one kind of service in one month.

REMEMBER, the person providing the service does not have to accept the Medi-Cal card, although most providers do accept it. Find out if the provider accepts the card *before* you go for treatment. It is your responsibility to give the provider the correct label at the time you receive a medical service.

Appendi



MEDI-CAL

California's Medical Assistance Program

STATE OF CALIFORNIA
EDMUND G. BROWN JR., *GOVERNOR*
MARIO OBLEDO, SECRETARY OF HEALTH AND WELFARE AGENCY
JEROME A. LACKNER, DIRECTOR OF DEPARTMENT OF HEALTH

(Brochures may be obtained from any County Welfare Office)

Appendix D

STATE OF CALIFORNIA

INDIVIDUAL DEVELOPMENT PLAN FOR FUTURE JOB PERFORMANCE OF PERMANENT EMPLOYEES

STD. 637 (REV. 10-74)

805-010-1128-701
BOSICK JJR EMIL H
553-72-4224
10/78

ACCOUNT NUMBER	DATE OF THIS PERFORMANCE DISCUSSION
R	DATE OF LAST PERFORMANCE DISCUSSION
DEPARTMENT	EMPLOYEE'S HEADQUARTERS

PERFORMANCE OBJECTIVES—Goals for further improvements in job performance during the next year in order to meet or exceed standards for the employee's present job or to develop employee skills.	**PLANS FOR ACHIEVING OBJECTIVES**—Specific methods by which the employee can work toward accomplishing his or her performance objectives (in-service training courses, college courses, rotation, special work assignments for training purposes, etc.).

I HAVE PARTICIPATED IN A DISCUSSION OF OVER-ALL JOB PERFORMANCE

SIGNATURE OF EMPLOYEE ▶	DATE	SIGNATURE OF SUPERVISOR ▶	DATE

PERFORMANCE APPRAISAL SUMMARY

Of Past Job Performance of Permanent Employees

PERFORMANCE FACTORS	I	M	E*	COMMENTS *
QUALITY OF WORK: Consider the extent to which completed rk is accurate, neat, well-organized, thorough, and effective.				
UANTITY OF WORK: Consider the extent to which the amount work produced compares to quantity standards for the job.				
ORK HABITS: Consider the employee's effectiveness in organizing and using work tools and time, in caring for equipment and materials, in following good practices of vehicle and per- nal safety, etc.				
RELATIONSHIPS WITH PEOPLE: Consider the extent to which e employee recognizes the needs and desires of other people, ats others with respect and courtesy, inspires their respect and nfidence, etc.				
KING ACTION INDEPENDENTLY: Consider the extent to ich the employee shows initiative in making work improve- nts, identifying and correcting errors, initiating work activities, etc.				
ETING WORK COMMITMENTS: Consider the extent to which employee completes work assignments, meets deadlines, follows established policies and procedures, etc.				
ANALYZING SITUATIONS AND MATERIALS: Consider the extent to which the employee applies consistently good judgment in alyzing work situations and materials, and in drawing sound nclusions.				
PERVISING THE WORK OF OTHERS: Consider the em- yee's effectiveness in planning and controlling work activities, tivating and developing subordinates, improving work methods and results, encouraging and supporting employee suggestions r work improvements, etc.				
MINISTERING WORK PROGRAMS: Consider the employee's effectiveness in developing goals and standards, delegating responsibility, making decisions, applying policies, etc.				

neral Comments or Comments on Other Factors.

* The supervisor may make "Comments" only, or may use rating categories only, or may use either or both methods of appraisal on any performance factor, s he or she prefers. The rating categories are:

I—Improvement needed for performance to meet expected standards.
M—Performance fully meets expected standards.
E—Performance consistently exceeds expected standards.

Appendix

Procedures for Processing Department of Health Services Contract Request (HAS 1007)

The following detailed procedures correspond to the steps enumerated on the attached flow chart. These instructions supplement/modify the existing Contract Manual.

Steps

1 Program develops Contract Request (HAS 1007)* form. All items on the form must be completed. Therefore, program managers are initially responsible for data required for items one through fourteen and securing approvals delineated in items thirteen through seventeen.

NOTE: If the intended contract is for Personal Services, Checklist (HAS 1800) must be completed and attached.

2 Contract Request is submitted to section chief and branch chief for approvals (items 13 and 14).

2A Personal services contracts must be approved by: (1) the Civil Rights Office, and (2) the Personnel Services Branch. These two units will indicate their approval in the blank area of HAS 1007 to the right of items 13 and 14. This is a temporary arrangement that will be in effect until the current supply of these forms is exhausted. If the request is disapproved, a memo will be attached by the reviewing unit explaining their decision.

3 If approved, the Contract Request is forwarded to Budget Office for fund certification and approval. Item 15 is completed, signed, and dated by the Budget Office. If disapproved, Contract Request is returned to originating program.

4 Contract Request is forwarded to the Deputy Director responsible for the program that is initiating contract. Deputy Director approves the Contract Request on item 16. If disapproved, returned to originating program.

5 Contract Request (original and one back-to-back copy) is submitted to Contract Management Section (CMS) for review. If for a series of similar contracts (only contractor/money amounts differ) submit only one Contract Request with an attached page listing each Contractor's name/dollar amount. NOTE: Total dollar amount from attachment must be entered on Contract Request form, paragraph 5, "Estimated Amount: $________". If approved, Contract Management Section will issue a contract number (or numbers in case of a series

---

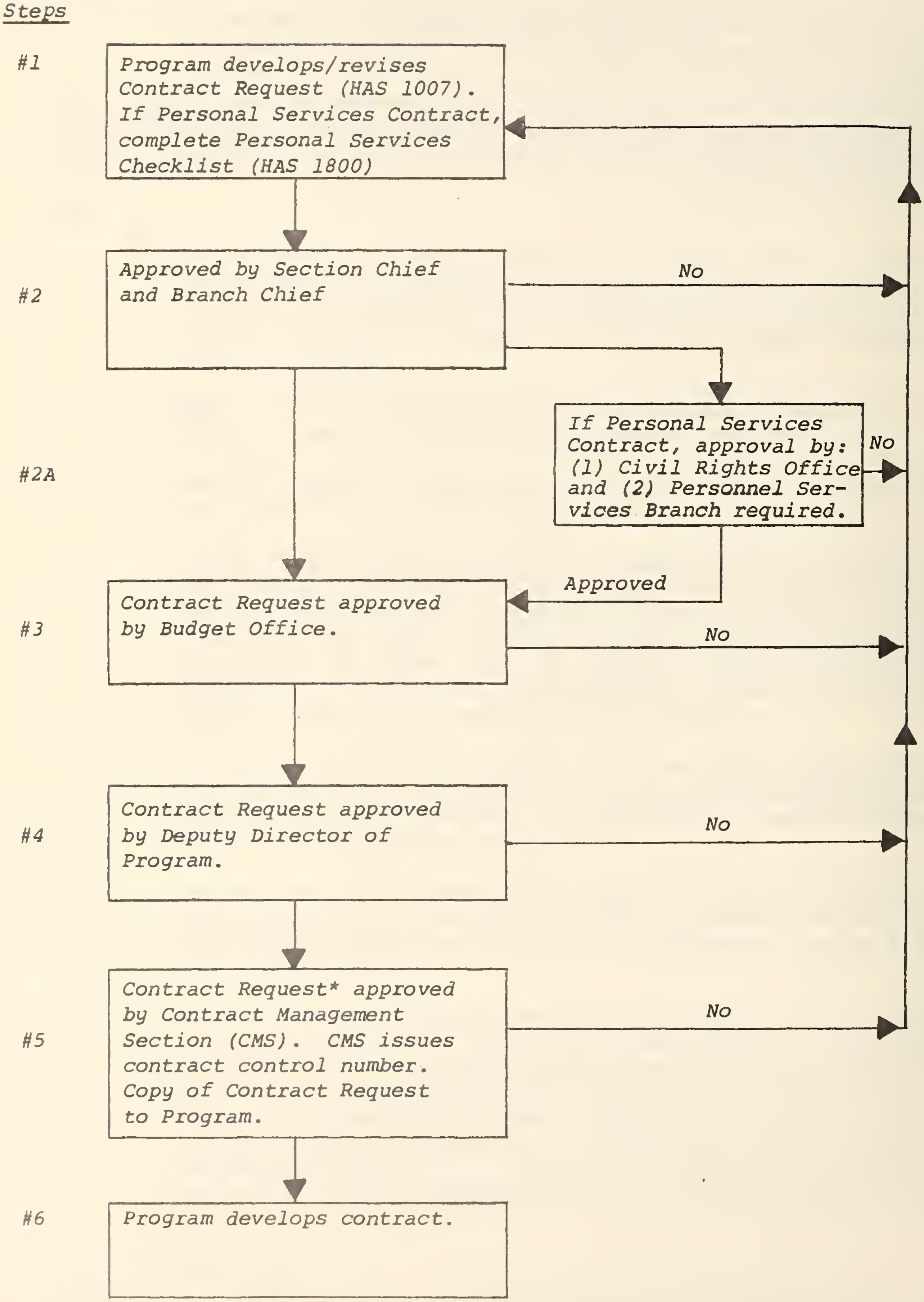
*All Department of Health Services contract forms are available from Department of Health Services Supply Unit (OB 9, Basement). All Std. forms are available from Department of General Services Stores (OB 8, Basement).

Step

on same subject) and return the copy of the Contract Request to the originating program. If disapproved, Contract Management Section will return, with explanation, to originating program.

6 Program secures appropriate forms and contacts Contract Management Section/Legal Office, etc., for guidelines prior to contract negotiation and writing.

CONTRACT REQUEST
(HAS 1007)
FLOW CHART


Steps
#1
Program develops/revises Contract Request (HAS 1007). If Personal Services Contract, complete Personal Services Checklist (HAS 1800)
#2
Approved by Section Chief and Branch Chief
No
#2A
If Personal Services Contract, approval by: (1) Civil Rights Office and (2) Personnel Services Branch required.
No
Approved
#3
Contract Request approved by Budget Office.
No
#4
Contract Request approved by Deputy Director of Program.
No
#5
Contract Request* approved by Contract Management Section (CMS). CMS issues contract control number. Copy of Contract Request to Program.
No
#6
Program develops contract.

*Note: Original and one copy (back-to-back) of Contract Request to CMS.

[illegible] ARE AGENCY DEPARTM[illegible]

ONTRACT REQUEST

ructions: See H.A.M. Section 3220 et seq.

[illegible] quest

Requesting unit:

Person to Contact:

Room No.:

Phone:

2. [illegible]

A. ☐ [illegible] contract

B. ☐ [illegible] for renewal or continuation of existing contract [illegible] ____________________

C. ☐ Amendment to current contract

No.: ____________________ to:

☐ Extend time ☐ Terminate

☐ Add funds ☐ Other

This Request Is for:

☐ One contract only ☐ Two or more contracts for the same subject. (Attach separate sheet listing each contractor and the dollar amount to be paid each one. Total to be entered in Paragraph 5 below.)

Name of Contractor (if known) and If an Individual, the SSA No.

Address:

Term: From to Estimated Amount: $

additional space is needed to answer any of the items below, use additional sheets and attach to this document.)

. Reason and necessity for the contract: (If consultant contract, state why work cannot be accomplished by state employees.)

. What are the specific objectives of this contract?

. What specific activities will contractor perform to achieve the objectives stated in paragraph 7?

9. How will the activities stated in paragraph 8 be measured in terms of outputs (e.g., number of persons served, number of medical procedures performed)

0. Will periodic reports, both programmatic and fiscal, be required? If yes, what type and how often. In addition, indicate the use to which these reports wi be put. If no reports are to be required, explain why not.

How will the [illegible] 's specified in paragraphs 8 and 9 be monitored and evaluated during the term of the contract?

12. What specific staff person will be responsible for the monitoring and evaluation of this contract?

13. Request Originated By:

Section Chief ____________ Date ____________

14. I have reviewed this request and determined it meets current program policy.

* Branch Chief ____________ Date ____________

15. Budget Office Information

Funds Available ☐ Funds not Available ☐ ☐ Approved ☐ Not Approved

AMOUNT ENCUMBERED $	Appropriation		Fund	
UNENCUMBERED BALANCE $	Item	Chapter	Statutes	Fiscal Year
ADJ. INCREASING ENCUMBRANCE $	Function			
ADJ. DECREASING ENCUMBRANCE $	Line item allotment			

Exempt from SAM 1209

Yes ☐

No ☐

Fund Source(s): ____________

Reviewed by: ____________ Analyst, Budget Office ____________ Date

Reviewed by: ____________ Unit Chief, Budget office ____________ Date

16. I have reviewed this request and determined it meets current departmental policy.

Deputy Director ____________ Date ____________

17. CMS approval by ____________ CMS Contract No. ____________ Date ____________

When completed, submit original and one copy of form to Contract Management Section, 714 P Street, Sacramento, CA 95814.

Upon approval, Contract Management Section will assign a contract number and return one copy to the originating unit. Originating unit may then prepare copies of proposed contract, two copies of the Contract Transmittal, Std. Form 15, and submit total package to Contract Management Section for processing.

**Instructions will be sent out indicating that for personal services contracts the request form must go to the Personnel Services Section for approval.*

STATE OF CALIFORNIA AGENCY DEPARTMENT OF HEALTH

CHECKLIST FOR PERSONAL SERVICES FOR CONTRACTOR OR SPECIAL CONSULTANT

Date:

1. Originating Unit (Branch or Section):

Person to Contact:

Room No.: Bldg. No.: Phone No.:

2. Name, address, and social security number of proposed contractor or special consultant:

3. Description of professional background and experience, if available, and/or resume including previous salary levels:

4. Description of and dates during which services are to be provided (From and To):

5. Description of the program need for these services.

Continued on reverse side.

6. What is the estimated cost of these services (each cost element should be separately identified, e.g., travel, per diem, overhead and proposed monthly salary)?

7. Justification for proposed reimbursement level (e.g., contractor's customary fee, competitive offers, comparable civil service salary):

8. Why can't Department of Health or other State employees provide these services (include description of any attempt made to identify current employees with the required background)?

9. Is the person eligible for civil service appointment? Is this feasible? If not, why not?

10. Have other persons been considered? If so, who and what is the estimated cost of their services?

Procedures for Processing
Department of Health Services Contracts

The following detailed procedures correspond to the steps enumerated on the attached flow chart. These instructions supplement/modify the existing Contract Manual.

Steps

1 Program meets (if necessary) with Contract Management Section and others for suggestions, guidelines, or requirements which will affect the contract writing process. Program negotiates and prepares final contract (Standard Agreement, Std. Form 2, or Interagency Agreement, Std. Form 13). Additionally, Contract Transmittal, Std. Form 15, will be completed and transmitted to Contract Management with the contract.

2 Originating program submits to Contract Management Section two copies of the Contract Transmittal one HAS 1091 (Statistic Sheet) and eight sets of each contract for review and further processing. If disapproved, Contract Management Section returns contract with explanation to program.

3 Contract Management Section forwards approved contract to contractor for concurrence and signature. Contractor returns contract to Contract Management Section.

3A Personal Services contracts are submitted by Contract Management Section to Deputy Director for Administration (per instructions from Health and Welfare Agency) for approval. If disapproved, returned with explanation to program.

3B Departmentally approved personal services contracts are submitted to Health and Welfare Agency for concurrence. If disapproved, contract is returned with explanation to program. Approved contract is returned to Contract Management Section.

4 Contract Management Section transmits contract to Department of Health Services Accounting Office for encumbering and certification of appropriate funding recordation. Contract is returned to Contract Management Section.

5 Contract Management Section determines and secures authorized departmental signature(s) on contract.

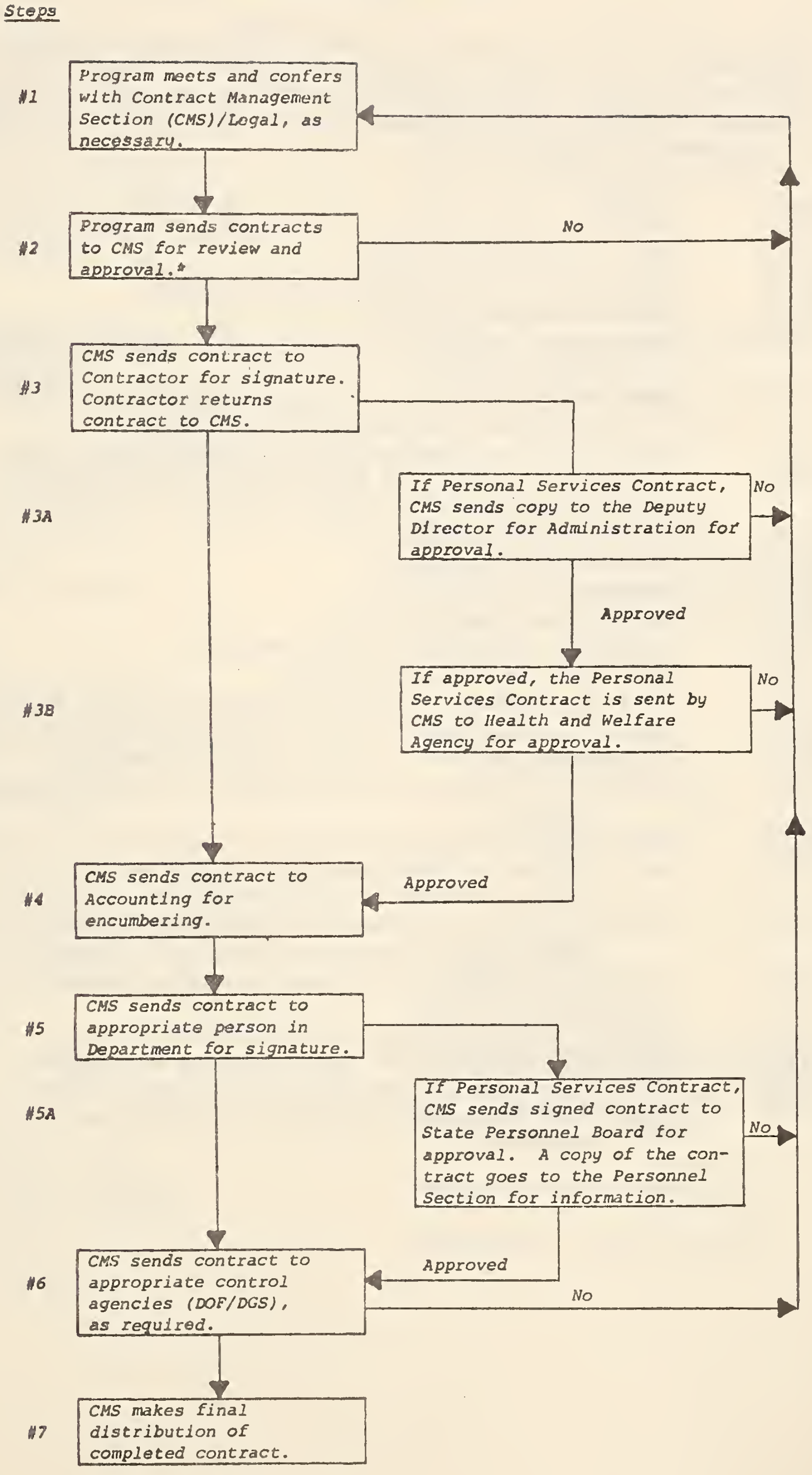
5A If Personal Services contract under State Personnel Board (SPB) jurisdiction, Contract Management Section transmits to SPB for approval (copy of contract to Personnel Services Branch for information). SPB returns contract to Contract Management Section. If disapproved, contract returned with explanation to originating program.

Steps

6 Contract Management Section sends approved contract to proper control agencies (Department of Finance/Department of General Services) as required by law. If disapproved, contract returned to originating program with explanation.

7 Final approved contract is distributed by Contract Management Section.

CONTRACT PROCESS
FLOW CHART


Steps
#1
Program meets and confers with Contract Management Section (CMS)/Legal, as necessary.
#2
Program sends contracts to CMS for review and approval.*
No
#3
CMS sends contract to Contractor for signature. Contractor returns contract to CMS.
#3A
If Personal Services Contract, CMS sends copy to the Deputy Director for Administration for approval.
No
Approved
#3B
If approved, the Personal Services Contract is sent by CMS to Health and Welfare Agency for approval.
No
Approved
#4
CMS sends contract to Accounting for encumbering.
#5
CMS sends contract to appropriate person in Department for signature.
#5A
If Personal Services Contract, CMS sends signed contract to State Personnel Board for approval. A copy of the contract goes to the Personnel Section for information.
No
Approved
#6
CMS sends contract to appropriate control agencies (DOF/DGS), as required.
No
#7
CMS makes final distribution of completed contract.

*Note: CMS will send contracts to Office of Legal Services for review when necessary.

Audits & Assessments

Below are examples of some of the audits and program operation assessments of the Medi-Cal program conducted in recent years. The first two were done by GAO, the third by the California Department of Finance, and the remaining by the California Office of the Auditor General.

Date	Title
3/75	SNF: Fire Safety (GAO)
4/76	Controls for Laboratory Services (GAO)
8/76	Medi-Cal Benefits (DoF)
2/75	Management Review of the California Community Mental Health
3/75	Administrative Review of the Organization and Staffing Policy of the Department of Health
3/75	Failure of the Orange County Prepaid Health Plan
4/75	Analysis of Costs and Application of Standards to Residential Child Facilities
4/75	Prepaid Health Plans
5/75	Provider Participation
6/75	Homemaker Chore Services
7/75	Health Care Deposit Fund
11/76	Update on Homemaker Chore Services
1/77	Long Term Care Reimbursement
1/77	Costs & Revenues of Claims Processing Subcontracts
2/77	Need for Reduction of Excess Acute Care Hospital Beds
3/77	Management Analysis of Third Party Liability
3/77	Eligibility Abuses & Deficiencies in Public Assistance Programs
7/77	Utilization Control Functions of the Medi-Cal Program
10/77	Deficiencies in Monitoring and Enforcing Quality of Care to Nursing Home Patients
11/77	Opportunities to Improve the Department of Health's Evaluation of Community Care Facilities
12/77	Lack of a Planned, Integrated System of Services for the Elderly
12/77	Update of In-Home Supportive Services
3/78	Hospital Licensing and Certification Procedures
3/78	Cash Management of the Health Care Deposit Fund
4/78	Attendance Reporting Practices of Physicians at State Hospitals

Appendix G.1.a

ADVISORY COMMITTEE ON HEALTH AND MEDICAL CARE SERVICES

Membership

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Deputy Director
Audit and Evaluation Division
Department of Benefit Payments
744 P Street, Rm. 1792, MS 17-20
Sacramento, CA 95814

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Berkeley, CA 94707

Lawrence Hart, M.D., MPH
Director, Health Care Services
County of Santa Barbara
4440 Calle Real
Santa Barbara, CA 93110

Clyde W. Oden, O.D., MPH
Associate Director
Management and Operations
Watts Health Foundations, Inc.
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Los Angeles, CA 90002

Mr. Robert Rippeto, Director
Social Services Division
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Los Angeles, CA 90024

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Inglewood, CA 90305

Mr. Ricardo Terrones
Administrator, Santa Marta
Hospital and Clinic
319 North Humphreys Avenue
Los Angeles, CA 90022

Mr. Arthur Weissman
Senior Vice President
Director of Medical Economics
Kaiser Foundation Health Plan
Ordway Building-Kaiser Center
Oakland, CA 94666

(2 vacancies - Title XIX)
(1 vacancy - HSA)

STAFF PERSONS

Daniel L. Lombard
Executive Secretary
Advisory Committee on Health
and Medical Care Services
714 P Street, Room 1540
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STATE OF CALIFORNIA

EDMUND G. BROWN JR., *Governor*

ADVISORY COMMITTEE ON HEALTH
AND MEDICAL CARE SERVICES

OFFICE OF EXTERNAL AFFAIRS

Department of Health Services
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SUBCOMMITTEES

ADVISORY COMMITTEE ON HEALTH AND MEDICAL CARE SERVICES

Alternative Health Systems Subcommittee

Lawrence Hart, M.D., Chairman

Adele Amodeo
Phillip M. Smith, Sr., M.D.

Subcommittee on Medi-Cal Data

Milton I. Roemer, M.D., Chairman

Arthur Weissman
Ricardo Terrones
Gary Adams

Finance Subcommittee

Clyde W. Oden, O.D., MPH, Chairman

Ricardo Terrones
Phillip M. Smith, Sr., M.D.

2 Board Certified Physicians	Phillip Smith, M.D. Milton I. Roemer, M.D.
2 Title XIX Representatives	(Vacant)
1 Member labor union consumer sponsored prepaid health plans	Clyde W. Oden, O.D., MPH
Director of Benefit Payments	Marion Woods (Gary Adams-designee)
Department Adds	
1 Non physician provider	Ricardo Terrones
1 representative from a health planning agency	Vacant
Chairman, Medical Care Committee County Welfare Director's Assoc.	Robert Rippeto
1 Prepaid Health plan physician or Administrator	Arthur Weissman
1 representative from Consumer Advocate Organization	Adele Amodeo
1 Representative from Local Government	Lawrence Hart, M.D.

1/ Federal Regulations - Attachment I

2/ Office of Legal Affairs opinion re: meeting federal regulatory requirements

Appendix G.1.c

LOG OF REQUESTS, RECOMMENDATIONS AND ACTIVITIES OF THE ADVISORY COMMITTEE ON HEALTH AND MEDICAL CARE SERVICES

Request, Recommendation or Activity (Date)	Origin of Activity (Date)	Action (Date)	Response or Resolution (Date)
1. Requested that recommendations be sent to Bruce Yarwood requesting that program changes recommended for the Medi-Cal program, regardless of source, be submitted to this Committee for screening, review and comment prior to any action by the Department and concurrently with review by the Department. (1-18-78)	Advisory Committee Meeting 1-18-78- Request by Advisory Comm. Chairman	Letter to Bruce Yarwood from Clyde Oden, cc: Lackner 2-22-78	Letter from Bruce Yarwood to Clyde Oden & A/C members transmitting issues w/caveat that Prop. 13 may have changed issues and will almost certainly change priorities! (June 23, 1978)
2. It was requested that a formal letter be sent through the Director of the Dept. of Health to the Dept. of Finance requesting that we have a responsible representative attend meetings. It was also requested that copies go to the Governor's Office, Agency Secretary, Assemblyman Keene and Senator Arlen Gregorio. (1-18-78)	Advisory Committee Meeting 1-18-78	Letter to Roy Bell, Director of Finance; cc: Lackner, Yarwood, Assemblyman Keene, and Senator Gregorio 2-17-78	Letter from Clyde Oden to Roy Bell, Director of Finance, much of Medi-Cal program related to fiscal considerations. Would very much appreciate representation from Dept. of Fin. at A/C meetings. (2-17-78)
3. The Committee recommended that a priority task of the Department of Health be the performance of a definitive study on the questions of private contract management of public hospitals including costs, quality and access to care. (4-27-78)	Advisory Committee Meeting 4-27-78	Letter to Bruce Yarwood signed by Oden, cc: Beach and Myers (5-19-78)	Letter from Yarwood to Oden 7-17-78 indicating this study must have demonstratable offsetting returns t the program--either in dollar savin or in improved program performance. The study should pose specific inquiries and have clrly. definable time
4. Requested a letter be sent to Yarwood w/ copy to Beach and Myers requesting that the issue of increased reimbursement for county Medi-Cal outpatient services be reopened. It was also requested that a copy of the letter go to appropriate Legislative members. (4-27-78)	Advisory Committee Meeting 4-27-78	Letter to Yarwood, Beach Myers & Legislative members(5-25-78)	Letter from Bruce Yarwood to Clyde Oden. With the approval of Prop. 13 the amount of general Fund money available for rate increases for Medi-Cal providers is limited. We will work to increase hospital inpatient rates. If funds are avail county hospital outpatient services are among our highest priorities. (6-16-78)
5. A recommendation to Bruce Yarwood and Beverlee Myers requesting their consideration of a formal conference of alternative health systems to be held some time in 1978 recognizing the impact that the outcome of such a conference would have on the Medi-Cal population. (4-27-78)	Advisory Committee Meeting 4-27-78	Letter to Yarwood & Myers s/b Oden 6-19-78	Letter from Yarwood to Oden suggesting that the AC pend this issue for 1978 while the Dept. assess program changes, them if the situation seems to so indicate, come forth with a new recommendatio ln 1979.

LOG OF REQUESTS, R̲ECOMMENDATIONS AND ACTIVITIES OF THE ADVISORY COMMITTEE ON HEALTH AND MEDICAL CARE SERVICES

Request, Recommendation or Activity (Date)	Origin of Activity (Date)	Action (Date)	Response or Resolution (Date)
6. Recommend the Chairperson advise to the Department of Health that the Committee is in favor of promoting county sponsored HMOs and that the Dept. pursue at least 2 methods of allowing this development: (1) Pursue amendments to federal HMO Legislation. (2) Explore other alternatives, including soliciting waivers from HEW, and other special attempts to achieve the Department's purposes. That the Dept. present to the Committee, by January 1979, an outline of the extent to which these objectives have been met. (5-31-78)	Advisory Committee Meeting (5-31-78)	Letter to Edwin Beach, cc: Beverlee Myers, Bruce Yarwood and Bruce Pomer s/b Oden (6-23-78)	Letter from John (7-26-78) Larrea to Dr. Oden summarizing the content of efforts and to provide back up material which is representative of the work the Department is doing to promote the county based HMO concept.
7. Recommend that the DOH design a mail questionnaire as much as possible using similar questions to those used in the survey of PHP surveys to obtain the views of Medi-Cal recipients and providers on the program and its administration. This questionnaire approach should be conducted periodically so the Committee can get trend information. (5-31-78)	Advisory Committee Meeting (5-31-78)	Letter to Myers, cc: Yarwood and Members s/b Oden (6-20-78)	Letter to Dr. Oden 10-10-78 S/B B.Myers Requesting survey specifics from the committee
3. Request the Director of Health to expand Committee membership to include 2 additional consumer beneficiary representatives preferably to reflect fee-for-service PHP enrollment and rural as well as urban consumers, and that the Department subsidize, to the maximum extent possible, the costs of beneficiary attendance and the meetings to make it as easy as possible for them to attend. (5-31-78)	Advisory Committee Meeting (5-31-78)	Letter to Myers, cc: Yarwood & Members s/b Oden (6-20-78) 1	SAME AS ABOVE: STATED that the Composition and program representation of this Committee meets her own & federal regulatory requirements. The question of additional reimbursement for consumer members is under review by Departmental Staff.
). Recommend to the Director that Committee membership be increased by 1 provider and that that provider be a practicing physician whose practice is predominantly Medi-Cal. (5-31-78)	Advisory Committee Meeting (5-31-78)	''''' ''	SAME AS #8 above

LOG OF REQUESTS, RECOMMENDATIONS AND ACTIVITIES OF THE ADVISORY COMMITTEE ON HEALTH AND MEDICAL CARE SERVICES

Request, Recommendation or Activity (Date)	Origin of Activity (Date)	Action (Date)	Response or Resolution (Date)
10. Recommend that in the interest of health and equity, the Committee urges support of funding for abortions in the Medi-Cal program and that the Committee ask the Director to transmit this information to the appropriate Legislative and executive branches of government with a copy to Beverlee Myers.	Advisory Committee Meeting (5-31-78)	Letter to Bev Myers 6-27-78 s/b Oden	SAME Letter as #7,8,9 - indicated the number of abortions that can be Funded through Medi-Cal were Severely limited by criteria enacted into the law by the Legislature.
11. Agreed to request the Director of Health Services to arrange a meeting with the Governor, the Director and other health officials to discuss the possible establishment of a blue ribbon committee to monitor the effect of Proposition 13 on health resources and if possible to identify trouble spots and minimize the dysfunctional effects of the initiative. (5-31-78)	Advisory Committee Meeting 5-31-78	Letter to Edwin Beach, cc: Myers, Yarwood, A/C members S/B Oden 6-2 -78	Letter from Beach to Oden indicating that the establishment of such a mechanism, prior to finalizing the State's assistance plans may be premature and the design of such a group should await announcements from the State, cities and counties to better assess the outcome of Stat and local government cooperative effort to maintain essential service The proposal will be communicated to the Governor.
12. Passed a motion that as a priority task, convene the subcommittee on Medi-Cal data on an ad hoc basis to meet and make recommendations to Ms. Myers on identifying data required for monitoring the effects of Proposition 13 on the Medi-Cal program.	ACHMCS Mtg. (6-28-78)	Held Subcommittee mtg. 6-18-78 to compose recommendations on data which could be used to monitor the impact of Prop 13 on the M/C program.	Submitted recommendations letter to Bev Myers s/b Weissman 8-2-78 Report submitted to Ms. Myer 8-15-78 in Final

REGION IX

DEPARTMENT OF HEALTH, EDUCATION AND WELFARE

HEALTH CARE FINANCING ADMINISTRATION

MEDICAID BUREAU

Eligibility

CALIFORNIA STATE ASSESSMENT

October 18-27, 1978

Participants:	Ian McLean	(RO Medicaid)
	Liza Barnes	(CO/Medicaid)
	Larry Spillan	(CO/Medicaid)

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CALIFORNIA STATE ASSESSMENT

ELIGIBILITY

Introduction:

The eligibility portion of the California State Assessment was conducted October 18-27, 1978, by Ian McLean (HCFA/Medicaid-Region IX) with the assistance of Liza Barnes and Larry Spillan (HCFA/Medicaid/Eligibility Policy Branch--Central Office). Staff representatives of California's Medi-Cal Eligibility Unit in Sacramento accompanied the Federal Team during the review. In addition to interviews in Sacramento with State Medi-Cal staff assigned to eligibility and related program areas, the assessment team visited Medi-Cal offices in the counties of Santa Clara, Marin, Los Angeles, and San Joaquin.

Each county in the State has responsibility for day to day administration of the California Medicaid Program, under overall direction of the California Department of Health Services. Supplementing its coverage of the categorically needy and medically needy, the State extends coverage to virtually every optional category for which Federal financial participation (FFP) is available.

NOTE: The first four findings in this section have been the subject of previous discussion and correspondence between the Regional Medicaid Office and the Department of Health Services. The views and concerns of the State as presented in those discussions and related correspondence have been considered in preparing this report. The related correspondence includes three letters to Mr. Lawrence L. McDonough, Regional Medicaid Director, from:

1. Mr. Richard H. Koppes, Chief Counsel, Office of Legal Services, dated October 3, 1978.
2. (Ms.) Beverlee A. Myers, Director, Department of Health Services, dated November 13, 1978.
3. (Ms.) Doris Z. Soderberg, Chief, Eligibility Standards Section, Medical Care Standards Division, Department of Health Services, dated November 17, 1978.

FINDINGS AND RECOMMENDATIONS:

Finding #1: Transfer of Property Restricitons Imposed on the Aged, Blind and Disabled Medically Needy

The State of California is imposing a transfer of property restriction on the aged, blind and disabled medically needy.

Pursuant to section 1902(a)(10)(III) of the Social Security Act (the Act) and 42 CFR 434.120, California has chosen to include all State Supplementary Payments (SSP) recipients who meet certain specified conditions in its Title XIX categorically needy program in addition to all Supplemental Security Income (SSI) recipients who are covered in accordance with Section 1902(a)(10)(A) of the Act.

With respect to the above-described option chosen by California, we have been advised by our legal counsel that a transfer of property restriction may not be imposed upon SSI recipients for purposes of determining Medicaid eligibility since such a restriction is not permitted for SSI eligibility purposes. Accordingly, a State that chooses the above-referenced option would not be fulfilling its obligation to make Medicaid assistance available to all SSI recipients (as required by Section 1902(a)(10)(A) of the Act) if it imposed a transfer of property restriction on the corresponding group of the medically needy in the State's Title XIX program.

We have been further advised, however, that pursuant to Section 1902(a)(10)(III) of the Act, and given HEW's position on collateral conditions expressed in 45 CFR 233.10(a)(1)(ii)(B), it would be legally permissible for the Secretary to allow a State that has chosen to include all SSP recipients meeting certain conditions in its Title XIX categorically needy program to impose a "transfer of property" restriction on such SSP recipients in those instances where the State administers its own SSP program. In this regard, though, California does not administer its SSP program, but has contracted with the Social Security Administration (SSA) pursuant to Section 1616 of the Act, to have SSA administer that program. Additionally, pursuant to Section 1634 of the Act, the State has agreed to have SSA make determinations of Medicaid eligibility on behalf of the State with respect to individuals residing in the State who are receiving (or are eligible to receive) Federal SSI payments and/or Federally administered State supplementary payments. Under these circumstances, therefore, no "transfer of property" restriction is imposed upon SSP recipients in California for purposes of determining Title XIX eligibility. Accordingly, under Section 1902(a)(10)(C)(i) of the Act it is not legally permissible for California to impose such a restriction on the corresponding group of the State's Title XIX medically needy.

The State responds that Section 1902(f) of the Social Security Act allows California to continue to impose more restrictive (than SSI) eligibility criteria than were in effect under the Medi-Cal program on January 1, 1972, and that its transfer of property restriciton meets that test. In order to utilize this option, the State must submit an appropriate State Plan amendment. If the State decides to amend its program in this manner, then it must apply to the categorically needy aged, blind and disabled the same transfer of property restriction it imposes on the medically needy aged, blind and disabled. In order to accomplish this, the State has suggested an arrangement whereby SSA would continue to determine Medicaid eligibility of all aged, blind and disabled SSI recipients and would additionally refer to the State those SSI recipients who have transferred property. Regional Medicaid Office contacts with the Regional SSI Office indicate the SSI is unwilling to agree to such an arrangement. It should be noted that currently serious consideration is being given to legislative changes to Title XVI to incorporate transfer of property restrictions. Under current law and regulation, if the State decides to exercise its option under Section 1902(f) of the Act, with respect to transfer of property restrictions, it must resume responsibility for determinations of eligibility of the aged, blind and disabled categorically needy and must apply such restrictions to this group.

Recommendation:

Absent pertinent changes in its Title XIX program or in Title XVI, California should amend its program to eliminate the "transfer of property" restrictions it imposes on the aged, blind, and disabled medically needy.

Finding #2: California's "Special Deduction" Allowed to the Aged, Blind and Disabled Medically Needy

The State provides a "special deduction" or "income disregard" to aged, blind and disabled medically needy applicants. The "special deduction" is not included in the set of deductions allowed under the SSP program or in the SSI program. Rather, this deduction is used solely in determinations of eligibility and "share of cost" in the State's Title XIX program.

The "special deduction" is equal to the difference between the applicable SSI/SSP payment level and the applicable medically needy maintenance level. (See California Title 22 Section 50555.4)

The only income deductions or disregards permitted the medically needy under Federal regulations are those allowed under the corresponding cash program per 42 CFR 435.831(a)(2). For aged, blind and disabled individuals and couples applying as medically needy in the State of California, the highest of the disregards allowed in determining financial eligibility for SSP (which are available to all eligible aged, blind and disabled individuals in the State) are to be deducted. The "special deduction" does not meet this test and is, therefore, not an allowable deduction for purposes of Federal financial participation.

The effect of the deduction is to provide a medically needy maintenance level in excess of the levels for which FFP is available as specified in 42 CFR 435.1007.

California responds that the "special deduction" simply ensures that the aged, blind and disabled medically needy population retains an amount of monthly income equal to the corresponding categorically needy population. Without the deduction, a small increase in personal income which renders an aged, blind or disabled person ineligible as categorically needy would result in a medically needy spenddown disproportionate to the increase in income. The State argues that it is unreasonable and inflexible to consider as income available to meet medical needs under the medically needy program an amount of income which, for the corresponding categorically needy program, is allowed for shelter, food and clothing.

Under current Federal law and regulation, a State's medically needy income standard must be uniform for all categories (aged, blind, disabled and families with dependent children), but, for purposes of FFP, may not exceed 133 1/3% of the highest cash amount paid to an AFDC family of the same size. It is the State that establishes the level of cash assistance in the AFDC program. In this regard, the State has determined that aged, blind and disabled individuals and couples need considerably more for shelter, food and clothing than does a comparable size family with children. It is this determination that gives rise to the inequity between the categorically needy and the medically needy aged, blind and disabled which the "special deduction" seeks to remedy.

It should be noted that the Medicaid Bureau has proposed to the Health Care Financing Administration that Title XIX be amended to permit medically needy income standards to vary by category of eligibility. Under its proposal, for each category, the medically needy standard would be required to be at least as high as the standard used to determine eligibility for a cash payment under the relevant cash program (AFDC, SSI or SSI/SSP). The maximum medically needy level for aged, blind and disabled applicants would no longer be restricted by any State's lower AFDC payment levels.

Recommendation:

Under current Federal law and regulation, the State must establish procedures to ensure that claims for FFP are limited to maintenance levels calculated on the basis provided in 42 CFR 435.1007.

Finding #3: Categorically Needy Coverage of the Aged, Blind and Disabled Receiving State Supplementary Payments or in Medical Institutions (or ICF's): The 300% Gross Income Limit

The State of California has an agreement with SSA pursuant to Section 1616 of the Act, whereby SSA administers the State's SSP program. SSA informs the State regarding those receiving SSP. The State provides Medicaid coverage to all persons in receipt of SSP, including those who have gross income in excess of 300% of the SSI payment level.

California may not extend categorically needy coverage to persons receiving SSP whose gross income is in excess of 300% of the SSI payment level pursuant to 42 CFR 435.230, 42 CFR 435.1005 and 42 CFR 435.1006. Such persons must establish their eligibility for Title XIX by "spending down" to the applicable "medically needy" level.

The State's response to this finding is that it is moot in view of the "special deduction".

Recommendation;

The State must establish procedures to assure that claims for FFP are limited per 42 CFR 435.230, 42 CFR 435.1005 and 42 CFR 435.1006.

Finding #4: California's Treatment of Parental Income and Resources Available to Children Under 21 in Family Groups Living Together When Making AFDC-Related Medically Needy Determinations

Irrespective of State law which confers adult status at age 18, the State must consider parental resources and income available to children to age 21 in family groups living together per 42 CFR 435.712(a) and (c), 435.811, and 435.831(c). Moreover, in medically needy determinations, the income and resource levels against which countable income and resources are compared are the general statewide medically needy levels. Such medically needy levels relate to the total family size of eligible and ineligible relatives whose income and resources are (or can be) considered available to the assistance unit after deducting all such relatives' incurred medical expenses.

The State of California has elected to extend Title XIX coverage to all financially eligible individuals under age 21. However, in many instances, the State does not adhere to the provisions of 42 CFR 435 highlighted above. For example:

A. If a non-categorically related person is at least 18 years old, but under 21, and is living with his or her parents, then--

    1. He or she applies on his or her own behalf as a single individual.

    2. He or she is measured against the medically needy level for one.

    3. The income and resources of his or her responsible parents are not considered available; only such income and resources as are actually available to him or her are considered in the eligibility determination.

B. If an AFDC-related person is at least 18 years old, but under 21, and is living with his or her parent(s) who refuse(s) to apply for Medi-Cal, then he or she would apply on his or her own behalf in the same manner as in A above.

C. The State permits any person in a family group to exclude themselves voluntarily from the Medi-Cal assistance unit and in the case of voluntarily excluded parent(s), the medical expenses of the voluntarily excluded parent(s) are not included in meeting the spenddown liability, if any.

D. The State makes provision that a person under 21 years of age may apply for Medi-Cal on his or her own behalf as a single person Medi-Cal assistance unit and may do so without consideration of the income and resources of responsible parent(s), when application is made for what the State terms "sensitive services" (e.g., family planning, abortions, drug addiction services, venereal disease services, etc.).

The State's response to this set of findings is that parents with children under 21 should be exempt from financial liability in those instances where the child can demonstrate financial independence. And, per 45 CFR 206.10(a)(11), California feels that it is in the minor's best interest to provide medical assistance for sensitive services without regard to parental responsibility since often children will forego needed medical care rather than face the emotional trauma of telling their parents of their particular medical condition. The State stresses that under this provision, Medicaid coverage is restricted to sensitive services only; that the medical conditions involved are likely to have long-lasting, debilitating effects on the patient if effective treatment is not received; and, that for some of the conditions (e.g., venereal disease, drug addiction) the consequences of non-treatment may extend to many persons other than the patient.

Recommendation:

The State must amend its program to conform with 42 CFR 435.712(a) and (c), 435.811 and 435.831(c).

Finding #5: Fair Hearings

Applicants are informed of their right to a fair hearing, both orally and in writing, at the time of application and redetermination. Furthermore, each 10-day notice of action includes information regarding the right to a fair hearing and how to obtain it. The single State agency (Department of Health Services) contracts with the Department of Social Services, Office of the Chief Referee, to conduct the hearings and to recommend a decision to the Department of Health Services (DHS). DHS may adopt, amend or return the recommended decision to the hearing officer for further consideration. If DHS adopts or amends the recommended decision, the dissatisfied party may request a rehearing which may be granted or denied at the option of DHS. Recipients are advised of their appeal rights as a part of the initial decision. Although the Medi-Cal program does not provide legal services to appellants, it does inform recipients of the availability of legal services in the community.

In November 1978, (a representative month) 57% (63) of the hearings were decided in favor of the appellant and 43% (47) were denied. The balance of the 427 requests for hearings were accounted for by withdrawals in favor of the client, abandonments of the case, and erroneous filings. Recipients have the right to a conference with the County Welfare Department any time prior to the hearing.

Section 50953(a) of Title 22 of California's Administrative Code provides that Medi-Cal Fair Hearings shall be conducted in accordance with the regulations and procedures of the Department of Social Services. The Department of Social Services is under court order (Washington vs. Obledo) to permit applicants or recipients a period of one year to appeal an agency action. Per 45 CFR 205.10(a)(5)(iii), applicants or recipients are provided reasonable time, not to exceed 90 days, in which to appeal an agency action. The Department of Health Education and Welfare (DHEW) is considering a change in 45 CFR 205.10(a)(5)(iii) to allow a year to appeal instead of 90 days.

Recommendation:

If DHEW does not change 45 CFR 205.10(a)(5)(iii) to permit a year to appeal, then the Regional Medicaid Office should initiate compliance proceedings to enforce the 90 day limit on appeals.

Finding #6: Restriction on Application of Prior Medical Bills In Determining Share of Cost

California does not permit medically needy applicants to apply the costs of medical care incurred prior to the month of application in the determination of share of cost (liability). Federal Title XIX policy provides that previous medical bills which remain the current liability of the applicant are to be considered in determining the share of cost. (See 42 CFR 435.831(c)(1) and Section 4.30.30.B.1.d of the Medicaid Eligibility Manual.)

Recommendation:

The State should amend its policy to conform to Federal policy in this area.

Finding #7: Application of SSI Budgeting Methodology

When an aged, blind or disabled medically needy couple ceases to live together (e.g., one enters an institution), California considers their income and resources mutually available only until the month after the month they cease to live together. Per 42 CFR 435.822, the State must, in this instance, consider income and resources mutually available for six months after the month they cease to live together.

Recommendation:

The State should amend its program to conform to 42 CFR 435.822.

Finding #8: Retroactive Spenddown of Resources

The State permits applicants to dispose retroactively of their excess assets in determining retroactive Medicaid eligibility. Although Title XIX regulations and Eligibility Manual material are silent on the matter of retroactive spenddown of resources in determining retroactive eligibility, the concept may have validity. (See Section 50421 of Title 22.)

Recommendation:

Further discussion should be conducted with the State regarding this practice.

Finding #9; Prospective Conditional Eligibility

The State of California has elected to extend Title XIX to all SSI beneficiaries. As such, "conditional eligibility" is available to categorically needy aged, blind and disabled persons who have entered into a written agreement to dispose of excess resources. California must allow medically needy persons whose resources exceed eligibility limits to enter into similar agreements with the State, under comparable terms and conditions. However, in no case may the State require applicants with excess resources to liquidate the excess by converting it to cash and actually paying the proceeds out for medical care. Of course, applicants may do so if they wish to establish eligibility.

California is not currently allowing medically needy persons whose resources exceed eligibility limits to enter into such agreements. The State reasons that its allowable resource levels are much more liberal than those for SSI and that, therefore, this particular rule has no relevance to its program.

Recommendation:

Further discussion should be conducted with the State regarding this practice.

Finding #10: Monitoring of 4-Month Continued Coverage Cases

As provided for in 42 CFR 435.112, certain families terminated from AFDC because of increased earnings or hours of employment continue to be eligible for Medicaid for four months beyond the month they become ineligible for AFDC cash. California extends coverage to such families, but does not continue to verify other potential factors of ineligibility (e.g., return of absent parent, increase in resources or in unearned income, change of residency). FFP is not available for those who become ineligible because of other AFDC eligibility factors.

The State also is exteding coverage to its Zero Base Grant cases which include families who would be eligible for an AFDC grant except that their income falls between the AFDC need standard and AFDC payment standard. The 4-month continuing coverage provision is extended to these cases when increased earnings places their income above the AFDC need standard.

The 4-month continuing coverage provision is intended only for those families terminated from receipt of an AFDC grant.

Recommendation:

The State should initiate continuing monthly review of earnings and hours of employment criteria of this group. The State should terminate coverage of the Zero Base Grant group under the 4-month continuing coverage provision.

Finding #11: Operation of the Program With a View to the Best Interest of Applicants and Recipients

By national standards, the Medi-Cal program is generous as to the scope of benefits provided and scope of groups covered. Furthermore, it is the consensus of the review team that, by and large, the State of California operates the Medi-Cal program with a view to assuring that those eligible for the program are given a fair opportunity to benefit by it.

Recommendation:

None.

Finding #12: Competence and Dedication of Staff

It is the general observation of the review team that the Medi-Cal eligibility function is being conducted by a competent and dedicated staff at the State and local levels.

Recommendation:

None.

Finding #13: Development and Implementation of a Medi-Cal Eligibility Manual

Medi-Cal eligibility staff at the county level expressed praise for the State for having developed and implemented a Medi-Cal Eligibility Manual for use by caseworkers. Local staff indicated that the Manual was helpful to them in the eligibility determination process.

Previously, there was no single, comprehensive manual governing Medicaid eligibility determinations. Local welfare workers were required to follow both the Eligibility and Assistance (EAS) Manual (issued by the then Department of Benefit Payments) and Medi-Cal letters (issued by the then Department of Health).

Recommendation:

None.

Finding #14: Medi-Cal Eligibility Forms

The various Medi-Cal eligibility forms help simplify the process of establishing and determining eligibility. For example, the MC 177, Record of Health Care Costs, is an effective means of recording the applicant's progress toward meeting his or her share of cost. Also excellent are the MC 216 and MC 217 setting forth the rights and responsibilities of applicants. These clear and comprehensive forms are provided to each applicant at the time of application.

Recommendation:

None.

Finding #15: Client Status Reporting

Supplementing its annual redetermination process, California requires that AFDC-related medically needy recipients submit a report on a quarterly basis indicating any change in circumstances that might affect continued Medicaid eligibility. This procedure was praised at State and local levels as an effective means of assuring timely and accurate reporting of changes in circumstances.

Recommendation:

None.

Finding #16: Clear and Timely Policy Assistance and Policy Dissemination

County Medi-Cal eligibility staff generally were very satisfied with the clarity and timeliness of assistance on requests for interpretations of Medi-Cal eligibility policy provided by

Department of Health Services staff. Local welfare offices generally praised the Department of Health Services regarding its dissemination of policy changes in the Medi-Cal program.

Recommendation:

None.

Finding #17: MC 170 Screening Pilot Project

SSI/SSP recipients living in the community are listed on the State Data Exchange (SDX) forwarded to the State by the Social Security Administration pursuant to the 1634 agreement. The State routinely forwards a Medicaid card to such categorically needy persons.

When an SSI/SSP recipient enters a long-term care (LTC) facility, his or her SSI maintenance need standard is reduced to $25. Therefore, there are persons whose countable income is below the maintenance need standard in the community (eligible to receive an SSI check) but exceeds the standard in a LTC facility (i.e., ineligible to receive an SSI check).

After such a person enters a LTC facility, he or she is not to be listed on the SDX as a recipient of SSI/SSP and, therefore, the State should not routinely send him or her a Medicaid card, since his or her Medicaid eligibility must be reexamined by the State to determine the amount of his or her liability.

However, if, as sometimes happens, SSA is not informed of the institutionalization or for some reason does not act on such information, then the person will continue to get an SSI/SSP check; will continue to appear as an SSI/SSP recipient on the SDX; and, will routinely receive a Medicaid card from the State without any liability. The practical result is overpayments in the SSI/SSP program and in the Medicaid program.

The State is planning to conduct a pilot test of a procedure which it hopes will help eliminate such overpayments.

Under California's Title XIX program, a person must obtain prior authorization from the State before a Medicaid financed placement in a LTC facility can be effected. Such prior authorization is recorded on the MC 170. The State is implementing what it calls the MC 170 Screening Pilot Project to be conducted in several counties. The project will utilize the receipt of the MC 170 as a signal that a Title XIX recipient has entered a LTC facility. This will alert the Title XIX program to take a new Title XIX application in order to establish the amount of patient liability, if any, and to notify SSA of the change in living arrangement.

Recommendation:

None.

Finding #18: Use of Eligibility Floaters

At least one county visited has a staff of eligibility floaters who are caseworkers used to cover caseloads of eligibility workers who are absent or when a vacancy occurs. The practice appears to be an effective means of ensuring adequate caseload coverage at all times.

Recommendation:

None.

Finding #19: Medi-Cal Eligibility Design System

California is designing an improved Statewide Medi-Cal eligibility system known as the Medi-Cal Eligibility Data System (MEDS).

Major features of the system will be as follows:

1. The Social Security Account Number (SSAN) will be used as the primary method of beneficiary identification and file access.

2. Medi-Cal eligibility data from AFDC, Medicare Buy-in, SSI/SSP, other county-determined eligibles, and prepaid health plans would be entered on a single Statewide on-line master file.

3. In addition to current eligibility data, the master file will contain a minimum of 15 months historical data.

4. Current total file replacement processing will be replaced by more efficient update transaction processing.

5. On-line inquiry and on-line emergency Medi-Cal card issuance will be available to all of California's 58 counties.

6. On-line inquiry also will be available to other governmental agencies, as needed, and the State's fiscal intermediaries.

Although MEDS is expected to improve substantially the data collection, storage, retrieval and processing of the Medi-Cal eligibility function, it is not intended to perform Medi-Cal eligibility determinations.

Recommendation:

None.

REGION IX
DEPARTMENT OF HEALTH, EDUCATION AND WELFARE
HEALTH CARE FINANCING ADMINISTRATION
MEDICAID BUREAU

Provider Relations

CALIFORNIA STATE ASSESSMENT

August 20-September 1, 1978

Participants: Henry F. Tyson (RO/Medicaid)
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EXECUTIVE SUMMARY

The present review of provider relations in California revealed a wide variety of specific complaints and problems of the provider community. In general, health care providers felt that most of the problems they experience in the program result from the philosophy of the State Government to cut costs even when such efforts result in policies that inconvenience the providers of services.

During the past year and a half, all provider associations reported a positive change in the Department of Health Services' (DHS) willingness to listen to the concerns of the provider groups. While this change is noteworthy, most providers feel that it is still too early to evaluate the effect of the State's change in attitude. Some feel that even if DHS and the provider community work more closely together, that any substantive changes in the program would still be subject to the scrutiny and possible veto of the State's Department of Finance.

It is suggested that the State and the health care provider community continue to work more closely together to resolve existing problems between them. This relationship is seen as important because it ultimately affects availability of health care for the State's nearly four million Medicaid beneficiaries.

PROVIDER RELATIONS

I. Introduction

From August 28 through September 22, 1978, a Medicaid Bureau review team assessed the relationship between the California Department of Health Services (DHS) and the professional health care providers in the State. The review team interviewed various provider associations, DHS staff, and the State fiscal intermediary (Medi-Cal Intermediary Operations) in order to determine:

- How well the State encourages provider participation in the development of program policy, and
- How easily the State and the provider community are able to resolve problems.

The following report addresses these areas and presents several recommendations for the improvement of provider-State relations.

II. Past Findings and Recommendations

A. In February of 1975, a review of California's Medicaid program and provider relations was undertaken by the Medical Services Administration. An initial consideration of the present assessment was to review the status of the problems (findings) noted in the earlier review.

1. State Organization

Now, as then, DHS does not have an identifiable focus of responsibility for provider relations. Contact between health care providers and DHS is almost exclusively through the Medi-Cal Intermediary Operations (MIO).

Recommendation

DHS should identify a component to be more responsible for ongoing relations with health care providers in the State.

2. Medicaid Advisory Committee

In 1975, it was found that the Medicaid Advisory

Committee (Advisory Committee on Health and Medical Care Services) was not a focal point for resolving health care provider problems. Sometime after the review, the Committee ceased to have regular meetings and was dissolved by Statute on January 1, 1977.

The Committee was later reconvened in October 1977. Though the new Committee appears to have the support of DHS and is attempting to develop its role in influencing program policy, several provider associations (e.g. physicians and private hospitals) interviewed felt that their interests are not currently represented by the membership of the Committee. In addition, it was found that health care consumers (Medicaid beneficiaries) were underrepresented on the Committee.

Recommendation

DHS should review with provider associations the current membership of the Committee to assure that both health care provider and consumer groups are adequately represented on the Committee.

3. Posture of DHS Toward Provider Participation in Policy Development

In 1975, it was found that there was little health care provider participation in Medicaid program policy development. The present review revealed a positive change in the State's willingness to actively involve providers in the program. The change appears to have occurred during the past year and a half with the appointment of the present Deputy Director of the Division of Medical Assistance and reinforced by the more recent appointment of a new Director of DHS (the single State agency). Though the majority of provider associations interviewed supported this finding, most felt that it was too early to predict whether the change would have an impact upon the program.

Recommendation

DHS should continue to promote the participation of the health care provider community in the development of the State's Medicaid program.

4. Performance of the Fiscal Intermediary

The 1975 review found that the fiscal intermediary (Medi-Cal Intermediary Operations-MIO) was generally processing provider claims for services in a timely manner and to the satisfaction of the providers. In addition, the review noted that the provider relations staff at MIO had developed what appeared to be an effective provider training and liaison program.

At the present time, DHS is in the process of changing fiscal intermediaries. The review revealed considerable apprehension of the provider community that the new fiscal intermediary (Computer Sciences Corporation) would be unable to perform at the same standard as the old fiscal intermediary for some time.

Recommendation

DHS should regularly meet with representatives of all health care provider groups to inform them of the progress being made on the change-over in fiscal intermediaries and any problems that may arise during the transition period.

5. Provider Participation

In calendar year 1978, a total of 40,338 providers of services submitted claims of $600 or more and of these 25,994 were physicians. The 1975 program review found wide-spread discontent among health care providers in the State, which was thought to threaten the availability of providers to serve Medicaid beneficiaries. Though current estimates of provider participation in the program are problematic, a review of DHS statistics (see Appendix B) and a California Medical Association study of provider participation indicate that the actual number of providers in the program has remained relatively constant.

It is cautioned that this finding is tentative and only indicates that the crisis predicted in 1975 has not developed.

Recommendation

DHS should conduct a study to accurately determine the actual health care provider participation rates in all geographical areas of the State.

6. Prior Authorization

In 1975, it was found that health care providers were avidly opposed to the State's prior authorization system (Treatment Authorization Request-TAR) and the use of "sticky labels" for services. Since 1975, the "sticky labels" system has been modified and prior authorization eliminated for most physician services and non-formulary drugs. These actions by DHS were welcomed by the providers, though some physicians still feel that prior authorization for inpatient hospital care is administered by the State in an arbitrary and inconsistent manner. Consequently, strong support, especially among hospital associations, was found for Professional Standards Review Organizations (PSRO's) to replace the State's TAR system.

Recommendation

DHS should negotiate with existing PSRO's in the State to enter into a memorandum of understanding for Title XIX medical reviews.

7. Excessive Paperwork

Complaints about bureaucratic "red tape" and excessive reporting requirements remain a major complaint of all provider groups. Despite the strong support of the California Hospital Association and other provider groups, the State decided against implementing the HEW Uniform

Billing Form (UB-16). Implementing this form would establish one common and simplified billing form for both Medicaid and Medicare.

Recommendation

DHS should work with DHEW to develop and implement a uniform billing form that would be mutually acceptable.

8. Low Physician Reimbursement Rates

On both reviews, physician providers felt that the level of reimbursement was a disincentive for participation in the Medicaid program. The California Medical Association states that the rate of reimbursement for physicians services has only slightly increased (reported at 12%) since the inception of the program.

Recommendation

DHS should form an Ad Hoc Reimbursement Committee, comprised of both State Agency and health care provider association representatives, to consider and recommend possible courses of action to ameliorate this and other provider reimbursement problems.

III. Current Findings and Recommendations

The major problems most frequently voiced by professional health care providers are summarized and discussed in the following sections:

A. Provider Complaints on Reimbursement

1. The State's sixty-day billing requirement is unreasonably restrictive and punitive.
2. Delays in reimbursement result in cash-flow problems for nursing homes and hospitals.
3. Due to month to month changes in beneficiary eligibility, many health care providers (especially hospitals, nursing homes, dentists and optometrists) are not reimbursed for services begun during one month and ending in

another.

4. Differential reimbursement for inpatient (cost related) and outpatient (schedule of maximum allowances) hospital services is unreasonable and leads to over-utilization of inpatient services.

5. Nursing homes should not be penalized on a day by day basis for late submittals of re-authorization for services forms.

6. Common Title XVIII and XIX audits would lead to lower hospital administrative costs.

7. Despite having one of the most liberal Medicaid program packages in the nation, the State Agency is constrained from providing adequate reimbursement to health care providers.

The State's sixty day billing limitation was mentioned most often by all provider groups as a major obstacle to participating in the program. Under California State law, a claim must be received by the fiscal intermediary within sixty days after the date of service. If the provider fails to meet this deadline, regardless of the reason (e.g., lost in the mail, provider administrative problems, etc.), the provider can not be reimbursed without a very lengthy and cumbersome appeals process. The reason given by the State Agency for this limitation is that it functions as a cost saving device. From the providers' perspective, this practice would seem unfair when recognizing that the provider rendered the necessary services in good faith.

Differential reimbursement rates and reimbursement penalties are all problems that would probably require amendments in State law to resolve. It is felt, however, that the State Agency should work with provider associations to seek ways to ameliorate these reimbursement problems. In addition to working with the associations, the State Agency can also act as a health care provider advocate before the State Legislature for mutually acceptable and desirable Medicaid program changes.

Other problems such as changes in eligibility, "date of service" restrictions, delays in reimbursement and adoption of common audits may not require changes in State law. It is understood that the feasibility of using an on-line computer eligibility file and changing the "date of service" to date of initial order for services is currently under consideration by the State Agency.

Recommendation

DHS should establish the Ad Hoc Medicaid Provider Reimbursement Committee mentioned earlier as a recommendation under finding #8. In addition, DHS should continue its long standing negotiations with DHEW to develop the terms and conditions of common audits for both the Medicare and Medicaid programs.

B. Communication Problems

Summary

1. Lack of provider Medicaid manuals and the inadequacy of the current Medi-Cal Bulletin system.

2. The State Agency has provided very little information to provider groups on the change of fiscal intermediaries.

3. Little information is given to health care providers on practices which are considered abusive or fraudulent.

The fiscal intermediary (MIO) is responsible for provider communication and training. Though provider groups are generally satisfied with the training that has been given in the past, they feel that the Medi-Cal Bulletin issuance system does not provide them with an easy to use and updated reference guide.

In the area of program integrity, providers felt that little information is shared with them through either Medi-Cal Bulletins or provider training. The only time program integrity issues are mentioned, is when a provider initially enters the program and is given training on how to submit claims.

Recommendation

DHS should develop and distribute Medi-Cal provider manuals to all health care providers in the State. In addition, a section of the manual should enumerate and explain Federal and State laws and regulations on program integrity issues.

C. Program Integrity

1. There appears to be no developed mechanism between provider associations and the State for referring aberrant providers for corrective action.

2. There appears to be no established means by which provider associations refer recipient fraud to the State.

Few provider associations refer aberrant providers to the State's SURS Unit or are aware of how to contact DHS's investigation unit. An aberrant provider or program integrity complaint received by a provider association is usually resolved through peer education and pressure by their association. However, if these methods are not successful, the provider is only asked to resign from the association and the matter is not referred to DHS for corrective action.

Medicaid beneficiaries suspected of fraudulant activity by a provider are seldom referred to the State for investigation. The State's SURS unit was mentioned as a place where providers might refer such beneficiaries, though there did not appear to be any ongoing communication between provider and the State in this area.

Recommendation

a) DHS should regularly make known to provider groups those channels already established for referral of suspected recipient and provider fraud and abuse.

b) Federal Regulations (Section 445.22) require the State to notify providers and recipients of penalties for fraudulent acts. The State should authorize the release of an appropriate Medi-Cal Bulletin.

Appendix A

Listing of Health Care Provider Associations and Single State Agency Offices Visited

Health Care Provider Associations

A. California Medical Association

B. Union of American Physicians

C. Los Angeles County Medical Association

D. California Dental Association

E. California Optometrical Association

F. California Pharmaceutical Association

G. California Hospital Association

H. Hospital Council of Southern California

I. California Association of Health Facilities

J. California Association of Homes for the Aging

Single State Agency

A. Department of Health Services

  Medi-Cal Division

  Medical Care Standards Division

B. Medi-Cal Intermediary Operations

APPENDIX B

PROVIDERS ENROLLED AND PARTICIPATING IN CALIFORNIA'S MEDICAID PROGRAM

CALENDAR 1978

	Total Number of Licensed Providers-3/79	Providers Enrolled in Medicaid-3/79	Providers Participating in Medicaid-1978[1]
Physicians	50,481	45,168	31,721
Dentists	18,161	N/A	12,950
Pharmacies	6,950	6,469	5,127
Physical Therapy	5,207	1,743	411
Laboratories	1,950	1,004	885
Chiropractors	4,961	3,610	1,804
Podiatrists	1,122	1,375	1,204
Optometrists	3,271	2,964	2,946
Other Professional	Undetermined	7,549	6,791
Hospitals	615	622	652[2]
Skilled Nursing Facilities	1,149	1,308	1,272
Intermediate Care Facilities	39	35	45[3]
Home Health Agencies	197	137	108
Prepaid Health Plans	13	13	13
Outpatient Clinics	656	585	440
Other Institutional	Undetermined	4,772	2,223
Child Health Disability and Prevention*			

* See next page

1/ Those submitting at least one claim to Medicaid during the most recent fiscal or calendar year.

2/ Hospitals may have more than one provider number.

3/ Some SNF's will bill as ICF's under certain conditions.

Source: California Department of Health Services

APPENDIX B (con't)

NUMBER AND PERCENT OF CHDP PROVIDERS BY TYPE[1]
CHILD HEALTH AND DISABILITY PREVENTION PROGRAM
1978

PROVIDER TYPE	NUMBER OF CHDP PROVIDERS	PERCENT
ALL PROVIDERS	4,002[a]	100%
County hospital-outpatient	52	1.3
Community hospital-outpatient	49	1.2
Organized outpatient clinic	146	3.6
O.E.O. clinic	5	b
Private corporation	146	3.6
Non-profit corporation	121	3.0
Professional society	3	b
Day care center	6	b
Schools	47	1.2
Prepaid health plan	61	1.5
Physician group practice	458	11.4
Physician solo practice	1,292	32.3
Dentists	621	15.5
Optometrists	442	11.0
Psychologists	188	4.7
Audiologists	38	.9
Occupational Therapist	1	b
Physical Therapist	2	b
Speech Therapist	70	1.7
County Health Department	85	2.1
Other	169	4.2

[1] CHDP providers include all 21 provider types. Group practice physicians and institutions, i.e., county hospitals, organized outpatient clinics, and schools, were counted as a single provider, thus understating the total number of individual providers in the CHDP program.

[a] Includes approximately 10% inactive providers.

[b] Less than .05 percent.

Source: State of California, Department of Health, Child Health and Disability Prevention Program, Center for Health Statistics.

REGION IX

DEPARTMENT OF HEALTH, EDUCATION AND WELFARE

HEALTH CARE FINANCING ADMINISTRATION

MEDICAID BUREAU

Reimbursement

CALIFORNIA STATE ASSESSMENT

September 20-October 14, 1978

Participants: Rich Bortoli (RO/Medicaid)
Bill Huey (RO/Medicaid)

REIMBURSEMENT

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I. Hospital Reimbursement

A. Payment Rates for Hospitals

The Medi-Cal program reimburses California hospitals on the basis of reasonable cost using the reimbursement principles of the Medicare program, except for the few items which are not allowable under the Medicaid program. Payment rates for hospital care are set on a retrospective basis. The Department of Developmental Services (DDS) is responsible for rates for the State Psychiatric hospitals and the State mental hospitals. The Department of Health Services (DHS) is responsible for rates for all other hospitals in California. DDS and DHS use identical methods to establish the payment rates.

The payment rates are based on a review of cost reports during the "Interim Rate/Tentative Settlement" process. This process consists of quickly reviewing cost reports to assess mathematical accuracy and to determine whether any obvious unallowable costs should be excluded. Once the accuracy of the cost report is verified, one overall interim rate is established for each hospital. Normally interim rates are not recomputed during the year. This process is the same for DDS hospitals with one exception. The DDS hospitals receive separate rates for room and for ancillary services while DHS hospitals receive one all-inclusive rate.

B. Cost Report Analysis for Hospitals

State regulations require that all hospital cost reports for DHS hospitals be submitted to the Audit Branch within three months of the end of the provider's fiscal year. The Audit Branch tests each cost report for "acceptance". The test is the Interim Rate/Tentative Settlement process which consists of verifying the mathematical accuracy of the cost report and deleting any claims for obvious unallowable costs. Once a cost report has been "accepted" it is logged in and earmarked for either a desk review or a field audit.

The Audit Branch maintains a log to control the status of the cost reports. The log includes the date the cost report was accepted, the date the interim rate process was completed and the date by which the audit must be completed (3 year statute). When there is only 1 year remaining under the statute, the appropriate field office is notified. The Audit Branch assigns field audits to one of its five Field Offices based on the resources of the office. Hospitals to be audited are prioritized.

Proprietary, county and larger hospitals receive the highest priority. If a desk review indicates that a field audit is necessary, one of the hospitals scheduled for a field audit is given a desk review instead. Conversely, if after beginning a field audit it appears that only a desk review would suffice, another desk review will be elevated to a field audit. All audit results are extensively reviewed by the Sacramento headquarters of the Audit Branch prior to issuing the final report.

C. Cost Report Settlements for Hospitals

The fiscal agent accumulates hospital charges, payments and patient days as they are billed. This data is available to the Audit Branch about 9 months after the end of the providers' fiscal year. Variances between fiscal agent data and provider data as shown on the cost report are reconciled during the State's audit of the cost report. The variances are normally due to differences between cut-off dates.

As previously mentioned, the State makes an interim settlement based on the cost report received from the provider. The provider is required to send in a check for the amount of the overpayment shown on the cost report. The original amount of the difference in cost and amounts received may be adjusted as a result of the State's interim settlement procedures "acceptance" review, etc. After the "acceptance" process is completed, the State notifies the provider (through letters sent by the fiscal intermediary) of the interim settlement amount.

The fiscal intermediary will make a lump sum settlement with the provider for underpayments or request immediate payment from the provider for the full amount of any overpayments. If the provider negotiates an extended pay back agreement (no more than 12 months) the fiscal intermediary automatically offsets monthly payments to the provider. The fiscal intermediary will offset future payments due the provider for current claims submitted if prompt payment of overpayments is not made.

D. Finding and Recommendation

Problem Area: Cost of Inpatient Hospital Services

Medi-Cal payments to county and community hospitals for inpatient hospitals are increasing at an alarming rate. The Federal and State expenditures in California for these hospitals have doubled since FY 1974, and in FY 1978 exceeded $1 billion. The California Health Facilities Commission is projecting an increase of $174 million for FY 1980.

Medicare regulations require that inpatient hospital reimbursement be on a reasonable cost basis. However the Medicaid regulations give the States much more latitude in developing reimbursement systems for inpatient hospitals. Medicaid regulations at 42 CFR 447.261(d) allow a State to develop an alternative reimbursement system for hospitals provided that the system includes (i) a provision for incentives for efficiency and economy, (ii) a provision that payment rates not exceed Medicare payment rates, and (iii) an assurance that an adequate number of hospitals will participate in the State's Medicaid program and that hospital services of high quality will be available to recipients.

Currently six States are reimbursing inpatient hospitals using an alternative reimbursement system. New York in 1970 became the first State to have an approved alternative system. Briefly, New York's system (i) groups the State's 300 hospitals according to size, location, patient mix and other factors, (ii) establishes payment ceilings according to the weighted average for each group for routine services and ancillary services, and (iii) sets minimum occupancy levels for certain services such as maternity, pediatrics, and medical/surgery services and lowers cost reimbursement for the services on the basis of imputed days. Medicaid program payment rates are about 20 percent less than Medicare in New York. Because of this system New York's inpatient hospital costs are increasing much slower than California's.

FY	New York	California
1975-1976	2.4%	15.0%
1976-1977	4.8	25.0
1977-1978	7.6	22.0

The California Department of Health Services has recognized the magnitude of the problem of increasing inpatient hospital costs and has proposed at least two separate methods designed to modify the present reimbursement system. One proposed system would have limited reasonable cost increases to a percentage. The State was not allowed to implement this system because of a successful law suit brought by hospital associations. The court's decision is currently under appeal. A second proposal would certify hospitals to participate in the program and contract with selected hospitals on a prospective basis.

Recommendation:

The Department of Health Services should continue its efforts to develop an alternative hospital reimbursement method designed to maintain a high quality of care as well as efficiency and economy. As a suggestion, the reimbursement methods followed by the six States with alternative methods should be studied. The portions of each program which seem to fit best into a California setting should be incorporated into a hybrid alternative reimbursement system for hospitals.

II. Reasonable Charge Determination (Non-Institutional Providers)

The current reasonable charge payment rates for all medical procedures except anesthesia were established by the State in September 1976. The State, through studies performed in 1974 and updated in 1976, established dollar conversion factors corresponding to the appropriate sections of the "1969 Relative Value Studies", fifth edition, published by the California Medical Association. The State did not consider specialities or subspecialities when the conversion factors were established. The conversion factors are used on a statewide basis. Payment rates for pathology were last updated in July 1977.

The data base for the conversion factors consisted of Medi-Cal claims paid during the period December 1975 through February 1976. Computer edits were performed on the services paid during that period to insure that the average amounts paid per procedure represented full Medi-Cal payments, unaffected by Medicare or other payment systems.

The conversion factors are:

Service	Factor
Medicine (Procedure Codes 90000-90470)	$ .69
(all other Procedure Codes)	.64
Pathology	.28
Radiology/Nuclear Medicine	3.00
Anesthesia	11.00
Surgery (Except Maternity)	29.75
Maternity	37.50

The State's fiscal agent pays the lesser of the amount billed by the provider and the amount obtained by multiplying the conversion factor value by the number of units (per the "1969 Relative Value Studies") for the procedure code billed. For "crossover" claims (claims for Medicare beneficiaries for whom Medi-Cal has paid Part B premiums) Medi-Cal will pay its share of the claim at the Medicare rate.

Prior to September 1976, the payment rates had not been updated since November 1972, when an across-the-board increase of 2.5 percent was allowed. That increase was made to the payment rates which were in effect at that time. The data base for these rates was charge data for 1967 and 1968.

Finding and Recommendations

Problem Area: Comparability of Reimbursement Amounts Between Medi-Cal and Medicare Programs

The State has not compared amounts that are allowable under the Medi-Cal program for individual medical procedures to the amount allowable for the same procedures under the Medicare program in California. Medicaid Regulations require that rates paid for medical procedures not exceed those paid by the Medicare program. The State believes that its payment rates (conversion factors) are low enough that the possibility of a Medi-Cal program reimbursement amount exceeding the amount allowed by Medicare is very slight. The State is basing its belief on the fact that the Medicare program's conversion factors (termed coefficients by Medicare) are significantly higher than those used by the Medi-Cal program. The conversion factors for Medicare exceed $1.00 for medicine, $.40 for pathology, $5.00 for radiology, $14.00 for anesthesia, and $50.00 for surgery. However, we were advised by the Medicare carrier in California that for certain medical services, the reimbursement is probably higher under the Medi-Cal program than the Medicare program.

Recommendations

1. The medical service reimbursement amounts under the Medi-Cal and Medicare programs should be compared to identify any procedures for which the Medi-Cal program may be paying more.

2. For those medical services identified above, DHS should establish controls in the Medi-Cal claims processing system to limit reimbursement to not more than the Medicare rate.

3. Whenever either the Medicare or Medi-Cal payment rates are updated, the process in recommendations 1 and 2 should be repeated.

III. Reimbursement for Drugs

The State established its own cost limiting system for drug reimbursement in 1972. The State's system now supplements the Federal MAC (Maximum Allowable Cost). The State's system is called MAIC (Maximum Allowable Ingredient Cost) and is comparable to Estimated Acquisition Cost (EAC). To establish a MAIC (or EAC) for a drug, the State makes studies to determine how and at what cost a pharmacy purchases a drug - i.e., direct from the manufacturer or through a wholesaler, minimum purchase amounts (volume of drug or dollars). MAIC's are established on a statewide basis. The MAIC is a limit on the amount a pharmacy will be reimbursed. Each individual pharmacy must bill its usual and customary charge but will not be reimbursed more than the MAIC.

In California, physicians must obtain prior approval for prescription drugs which are not in the State's drug formulary or which are going to cost more than the MAIC for the type of drug. To obtain prior approval, the physician must contact one of two Field Offices in the State. The two Field Offices are each staffed with a pharmacist consultant who is to determine, from the physician, the recipient's diagnosis and why a generic drug cannot be used. To approve deviations from the formulary, the pharmacist consultant issues a prior authorization form to the physicians. The form must accompany the prescription to the pharmacy and to the fiscal agent when the pharmacy submits its claim.

The State requires pharmacies to bill the Medi-Cal program for no more than the pharmacy's charge to the general public. The State's Surveillance and Utilization Review (SUR) Unit makes reviews of the billing practice of selected pharmacies to insure that they do not overcharge the Medi-Cal progarm. State records show that the reviews resulted in recoveries exceeding over $3 million in the 2 years ending June 1978. The State estimated the cost of making these reviews to be about $500,000. The SUR Unit had assigned 16 people to making reviews of pharmacy billing practices.

The State has developed a statewide dispensing fee which is currently $3.06 per prescription. The fees are updated about every 18 months. The current rate was established in May 1977. A recent study made for the State by a Certified Public Accountant (CPA) firm shows that pharmacy costs support this rate. This study consisted of mailing questionnaires to the approximately 5,000 pharmacies in the State. A total of 442 responses were received representing 527 pharmacies (includes chain operations). The CPA firm also field audited 32 pharmacies to verify data. The CPA firm's study was reviewed by a consultant hired by the California Pharmaceutical Association. No major differences were identified. California's dispensing fee appears to have been established in accordance with Federal regulations.

Finding and Recommendation

Problem Area: Reviews of Pharmacy Operations

In August 1978, the State discontinued routine reviews of pharmacies. This was primarily due to pressure from the California Pharmaceutical Association (CPhA) who brought suit against the State charging that the sampling techniques used in the pharmacy reviews were improper. With the discontinuance of the reviews, the CPhA has agreed to withhold its suit against the State.

Recommendation

Given the success of the pharmacy reviews, in the past, DHS should take whatever steps are necessary to reinstate reviews of pharmacy billing practices. It is anticipated that in order to implement this recommendation. DHS will have to resolve any sampling plan problems and adequately staff that portion of the SUR Unit which made the reviews in the past.

IV. Home Health Agencies

The State established prospective Medicaid maximum payment rates for Home Health Agencies (HHA) by periodically updating cost studies. The studies consist of arraying and analyzing costs by types of service - Physical Therapy, Occupational Therapy, Medical Social Service, Skilled Nursing Care, Home Health Aides, and Speech Therapy. The rates are determined by using a quartilized mean. Under this method, the State disregards the highest and lowest 25th percentile and the rates are established at the mean of the remaining costs. The State makes no adjustments for actual costs incurred by the HHA's. The last update resulted in rates that became effective August 1, 1977.

The current Schedule of Maximum Allowances:

Type of Service	Amount
Skilled Nursing Care	$ 26.10
Home Health Aide	12.40
Physical Therapy	23.60
Speech Therapy	32.75
Occupational Therapy	23.60
Medical Social Service	29.00

Finding and Recommendations

Problem Area:

Comparability of Reimbursement Amounts between the Medi-Cal and Medicare Programs

The State needs to determine that its payment rates for some HHA's do not exceed the amounts allowed under the Medicare program. Payment rates between programs vary because the Medi-Cal program bases payments on Statewide fixed amounts for each type of service and the Medicare program bases payments on reasonable costs of the individual providers. Discussion with Medicare intermediary personnel disclosed that the Medi-Cal Statewide payment rate is high enough that some Medicare payment rates may be lower than the Medi-Cal rate.

Recommendations

1. DHS should compare payment rates under the Medicare program and the Medi-Cal program to identify those providers receiving higher payments under the Medi-Cal program.

2. For those providers identified above, DHS should establish controls in the Medi-Cal payment system to limit reimbursement for these services to the Medicare rate.

V. Long Term Care Reimbursement

Long Term care facilities provide skilled nursing (SNF) and intermediate (ICF) patient care. These institutions are reimbursed according to a prospectively determined rate which varies according to the facility's bed-size and level of care. The rate is based on provider cost reports, adjusted for inflation, applicable program or regulatory changes, and estimated audit exceptions. The rate is then established for each bed-size/level of care class at the median of adjusted reported cost. This system was established pursuant to Section 249 of P.L. 92-603, which was implemented as 45 CFR 250.30(a)(3) and (b)(6) (now 42 CFR 447.272 - 447.316) July 1, 1976. The implementing regulations allowed a phase-in period lasting until January 1, 1978.

As of March, 1979, the State had still not implemented level-of-care classes based on cost reports. Additionally, as of March 1979 the State still did not have an approved State plan for reasonable cost-related long term care reimbursement.

Present System: The State's long term care reimbursement system, in place as of the latest on-site review (September, 1978) was based on provider cost reports received by late May 1978, the cut-off date for the (California) FY 1978-79 rate determination process. Out of 1100-1200 Medi-Cal providers, cost reports in usable form had been received from 874. The balance had either not been received or had been returned because of errors and omissions. Audits of these cost reports had been conducted on a first-in-first-audited basis. By the cut-off date, 59 cost reports had been field audited. Most of these providers had fiscal years which ended in the early months of 1977, the first cost reporting year under the regulation. It is not yet known whether the 59 facilities are reasonably representative of the total. No ICF's were included.

Audit adjustment percentages applied in the rate setting process were derived from the 59 audit reports as the average percent by which costs were overstated by providers in each bed-size class. The following results were obtained:

Bed-Size Class	Audit Adjustment Percentage
1-59	5.93%
60-99	4.98%
100+	3.44%

These results were applied to both SNF's and ICF's. For facilities with dual certification (SNF/ICF) an intermediate step was taken to determine per-patient-day cost for each type of care. To determine the SNF per-day cost, the reported, audit-adjusted cost was further adjusted for reported ICF days as a percent of the total. The adjustment assumed that SNF care required 1.57 times the amount of a nurse's aid's time as did ICF care, and that such care cost an average of $3.26 per hour. The adjusted cost data for each provider was then updated to a common point in time (June 30, 1978) so that facilities with varying fiscal years could be compared, by multiplying the reported cost by the number of intervening months from the mid-point of the provider's fiscal year times the Consumer Price Index. The resulting figure was further updated to the midpoint of the rate year (December 31, 1978) using a similar methodology, but substituting the State Department of Finance's estimate of 6.0% inflation during the rate year.

The final adjustment was for the estimated impact (including ripple effects) of an increase in the California minimum wage, passed in October, 1976.

The adjusted per patient day costs were then arrayed, low to high, in each bed-size class, and the median determined. This became the basic rate for SNF's. The rate a facility actually receives is somewhat higher than this, however, because it includes one of two "add-ons" depending on whether the facility has established an in-house training program for nurse's aids, or has contracted with a local community college or other resource to provide the training. This training is a state legal requirement (AB 3619).

Due to the lack of ICF data at this time, the State continues its practice of setting ICF rates at a percentage (currently 80%) of the SNF basic rate. This method results in a rate for ICF's which is not reasonable cost-related in that the rate is not related to the reported allowable costs of ICF's.

The rates for each class, determined according to the methods described above, including the add-ons by type of nurse training program, are as follows:

	Type of Training Program	
Facility Type	In-House	Contract
SNF		
1-59 Beds	$30.39	$29.84
60-99 "	28.59	28.29
100+	27.95	27.77

ICF

1-59 Beds	$24.27	$23.71
60-99 "	22.87	22.57
100+	22.36	22.18

Additional add-ons are paid to ICF's who have special programs for the developmentally disabled (DD) and SNF's who have either rehabilitation or sub-acute psychiatric programs for the mentally disordered (MD). These add-ons, based upon State estimates of additional cost, are:

ICF/DD	$4.54
SNF/MD	
-rehabilitation program	3.39
-sub-acute psychiatric program	3.83

The State's methodology is at variance with its reimbursement plan on a number of points. Moreover, the latest submittal of the plan has been questioned by the Federal government in terms of its specificity. Rather intense negotiations have taken place over the past several months, and resolution still has not been achieved. The State desires a greater amount of flexibility in setting rates from year to year than the regulations have been interpreted to allow.

The State's current position of not having an approved plan and not being able (for lack of data) to implement its present proposal leaves it vulnerable to court challenges. The sooner plan approval can be achieved, the better.

The plan thus far has not contained an explanation of how the rate setting methodology it describes is to be implemented, given that sufficient data was not and still is not available for initial rates. Therefore, legal challenges from public interest groups or the Federal government (after plan approval) would be made less likely if the State had such an implementation plan. Such a plan would have to assure that rates ultimately determined would be retroactive to the effective date of the approved plan.

Until recently, rate calculations were performed manually, using dozens of accounting worksheets and several weeks of staff time. This resulted in limited State capability to consider a large number of cost factors or changes in the methodology, or to arrive at timely financial impact analyses.

We understand that cost report data has been computerized, which should result in significant improvement in this area.

Alternatives to the present system: In the long run, it may behoove the State to re-evaluate its basic rate setting methodology. The class system as used by California suffers the inherent weakness that the rates for each of the 32 cells in the rate setting matrix is established in a vacuum. This presents a problem of theoretical soundness common to all of the many States which have this type of system. The problem is critical for classes with very few members. For example, how meaningful is the 55th percentile for a class with only two members? one member? no members?

One possible solution to this dilemma is to establish rates based on an econometric model. Such a methodology is already used by the State agency's Budget office to estimate Medi-Cal expenditures, including those for long term care. In an econometric model, the rate paid to a given facility would consist of a base rate, plus an add-on for each of the factors (geographic location, level of care and bed-size) that is known to affect cost. The add-ons are determined by linear regression of reported data using dummy variables. Such a method was impracticably cumbersome before the State acquired the use of a computer, but may be quite feasible now.

Additionally, there is known to exist a tendency on the part of nursing home operators to favor "light care" patients (who require relatively little attention), since the payment for them is the same as for the costlier "heavy care" patients. This results in extended hospitalization of many patients who could adequately be cared for in a long term care environment. Recognition of this additional cost through further breakdowns in level of care classes could help to alleviate the problem. It should be noted that such further breakdowns would aggravate the present problem that many class distinctions result in several small classes. Therefore, this concept should probably only be adopted if the econometric model is adopted.

Finally, the State's reimbursement system does not contain elements to give recognition to quality of care. Thus, a provider giving poor care by cutting corners is actually rewarded with greater profit. One way to reward good care would be to set up a point system using data and analyses currently being gathered by medical review teams and facility surveyors. Facilities could be reimbursed at varying rates, ranging between, say, the 10th and 90th percentile of facilities in their class.

Recommendations

1. We urge the State to submit a plan which can be approved by HEW. Regional and Central office personnel are available for any assistance the State may desire.

2. We recommend that the State develop an implementation plan which assures that rates ultimately determined will be applied retroactively to the effective date of the approved plan.

3. We encourage the State to continue to use automated systems for rate setting calculations.

4. We recommend that the State investigate alternative reimbursement systems, such as an econometric model, with a view to recognizing quality of care in the reimbursement context.

VI. Laboratories

During this assessment, a very limited review was done of the reimbursement system for laboratories because the HEW Audit Agency and the State's Surveillance and Utilization Review section were already making a very comprehensive review.

On August 11, 1978, the Audit Agency informed the Director, California Department of Health Services, that there were indications the State's maximum payment allowances for laboratory tests may be too high. The Audit Agency had reviewed price lists at 6 different laboratories for 10 frequently ordered tests. The Audit Agency determined that the maximum amounts allowed by the Medi-Cal program were 20 to 254 percent greater than the prices quoted to physicians by the 6 laboratories. During discussions with State and fiscal agent representatives, the Audit Agency found that laboratories generally charge the Medi-Cal program more for their services than they charge physicians. In addition the Audit Agency found through discussions with physicians that the services performed by the laboratories are the same whether the charge is to a physician or the Medi-Cal program.

On September 13, 1978, the Director, California Department of Health Services, acknowledged the Audit Agency's letter of August 11. The Director agreed with the Audit Agency's recommendation to revise the maximum allowances to reflect payment rates at which the tests are made available to physicians. The Director stated the Department's Rate Development Branch was undertaking a study of laboratories. The Director expressed concern about this situation and intended to make adjustments where necessary as soon as possible.

On February 8, 1979, the Audit Agency reported to the Director the results of its expanded review of laboratory pricing practices. In addition, the Audit Agency recommended a change to the State's automated laboratory equipment regulations contained in Section 51529 of Title 22.

The Audit Agency requested copies of 1977 fee schedules from 52 laboratories which received the larger amounts of Medi-Cal program payments in 1977. For various reasons fee schedules from only 30 laboratories could be used for this test. These 30 laboratories received about $7 million of the $21 million paid to independent clinical laboratories in 1977 by the Medi-Cal program. For these 30 laboratories, the Audit Agency attempted to compare the fees charged to physicians to the fees charged to the Medi-Cal program for the 50 laboratory tests with the greatest dollar volume. The comparison could be made for only 35 of the 50 tests because the data was not in a useable form for purposes of this project.

For the 35 laboratory tests for which comparisons could be made, the Audit Agency found that the Medi-Cal maximums exceeded the physician rates for 31 of the tests. In 1977, the Medi-Cal program paid $19,694,765 for these 31 tests. The Medi-Cal program paid $596,900 for the 4 tests for which the physician rates were higher than their Medi-Cal program maximums.

The Audit Agency did not make any recommendation as to what the Medi-Cal maximums should be. Rather, the data was provided to assist the State in its study of laboratory fees.

The Audit Agency also noted that the State payment policies, as described in Section 51529 of Title 22, do not fully reflect the current capabilities of automated lab equipment. There is equipment that can now perform on a panel basis certain tests that Medi-Cal pays for individually. For example, a Sequential Multiple Analyzer Computer (SMAC-24) can make at least 22 chemistry determinations on a single specimen. Under Section 51529, Title 22, 20 of these 22 tests are considered to be a panel and are reimbursed at a maximum of $19.10. However, Section 51529 does not recognize two of the 22 tests (triglycerides and CPK) to be part of a panel. As a consequence, labs which are performing the 22 chemistry tests on a SMAC-24 are permitted to bill for a panel of 20 tests and bill separately for each of the other two tests, thereby receiving additional reimbursement (a maximum of $6.72 for the two tests). The Audit Agency recommended that the State not only give consideration to lab rates charged to physicians but also take into account current equipment technology.

The Medicaid Bureau will monitor the activities and progress of the State regarding the study of laboratory fees. In addition, we will follow up with the State to insure that Title 22 is updated as necessary.

VII. Provider Audits

A. Audit Capability

The audits for DHS are the responsibility of the Audit Branch of the Audits and Investigations Division. The Audit Branch is functionally organized as a Headquarters office and four regional audit offices. The Audit Branch Headquarters, which is located in Sacramento, operates as a regional office, and also is responsible for final review of all audit reports, desk audits of cost reports, acceptance and mathematical accuracy verifications of all incoming cost reporting data and establishment of interim reimbursement rates for hospitals. The field offices are located in Sacramento, Emeryville, Hollywood and Santa Ana. Each office has a manager, audit supervisors, auditors and clerical and technical personnel. Each office is responsible for performing all field audit work required within its geographic area.

The Audit Branch plans to make audits of 1355 nursing home cost reports during the State's FY 1979. The goal is to make 964 desk audits averaging 8 hours each and 391 field audits averaging 100 hours each. Through December 31, 1978 the Audit Branch had completed a total of 431 desk and field audits. Considering that there are many audits in various stages of completion, Audit Branch personnel feel that they will meet their target of nursing home audits.

The Audit Branch has a goal of making audits of 868 hospital cost reports in the State's FY 1979. The plan is to spend an average of 20 hours on 409 desk audits of acute hospitals and an average of 175 hours on 459 field audits. Through December 31, 1978 a total of 124 audits have been completed with many audits currently in process. Audit Branch personnel believe they will meet their goal of completed hospital cost reports.

Once a common audit system is fully implemented in California, the Audit Branch can make more effective use of its resources. For the audits for which State will have responsibility, a higher ratio of field to desk audits with a more comprehensive scope can be accomplished.

B. Audit Appeals

All providers have the right to appeal the settlement decisions made by the State. The State's Title 22 sets forth the procedures and circumstances under which appeals may be made. When a provider appeals the State's decision to disallow certain costs but agrees with the decision to disallow other costs, the State will recoup only the overpayments related to those costs for which the provider agrees with the State's decision. The amount for which there is a disagreement as to either the disallowance philosophy or the amount is not recouped while the appeal process is under way.

C. Common Audits

There currently is no Title XVIII and XIX common audit agreement for auditing California providers. This situation results in duplication of audit effort at the expense of the taxpayer and provider frustration (and added cost) because provider staff time is taken up by two audit teams reviewing similar, and in some cases, the same data and records. California has proposed that it be responsible for auditing all institutional providers under the Medicare and Medicaid programs. The Medicare fiscal intermediaries, in turn, have made a proposal that they audit all institutional providers. Negotiations are under way to divide the audit workload such that both the State and the fiscal intermediaries will do common audits of providers serving both programs. The Medicaid and Medicare Bureaus of HCFA are combining their resources to monitor and aid the negotiations between the State and the Medicare intermediaries.

Recommendation

The State should continue to work with HCFA and Medicare intermediaries to implement a comprehensive common audit system for all California hospitals which will become fully operational as soon as possible, hopefully by the end of 1980. Full implementation of common audits will result in substantial savings for both the Medi-Cal and Medicare programs.

REGION IX

DEPARTMENT OF HEALTH, EDUCATION AND WELFARE

HEALTH CARE FINANCING ADMINISTRATION

MEDICAID BUREAU

EPSDT

CALIFORNIA STATE ASSESSMENT

November 6-17, 1978

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CALIFORNIA'S EPSDT ASSESSMENT

General Description:

In California the EPSDT program function is performed by the Child Health and Disability Prevention Program Branch (CHDP) which also provides State-only reimbursed screening services for children entering first grade of families who earn up to 200% above poverty, Head Start enrollees, and State Pre-School enrollees. The CHDP Branch is part of the Community Health Services Division of the Department of Health Services. EPSDT program services are available to AFDC recipients and other Medi-Cal eligible persons under 21 years of age. These services are provided within the frame-work of local County CHDP Programs which are administered by the local County health departments.

At the State level the CHDP Branch statewide-coordinates activities such as: data tracking, provider education, and training county welfare staffs in informing and referral procedures. This also includes coordination of similar activities with the Alternative Health Systems Branch which regulates the activities of Prepaid Health Plans. A working agreement exists between the CHDP Branch and the Social Services Division for coordinating the development and implementation of Social Services regulations governing County Welfare Department responsibilities in CHDP. Both these divisions, along with other departments such as the Department of Education (school health) and the Department of Social Services, participate on the State's CHDP Coordinating Committee which serves to develop joint policy affecting the program.

The State of California consists of 58 counties which have been divided into four regions: Coastal (15 counties), Central (19 counties), Southern (8 counties), and Contract counties (16 counties). The Contract counties are defined as counties with less than 40,000 population which are eligible to contract with the State for public health services rather than provide their own CHDP services. Each of the other 3 regions is assigned a State OHDP Regional team of specialists which is comprised both of CHDP and Social Service Division staff and which usually includes a registered nurse consultant, Health Program Advisor (for fiscal review), a social service consultant, and support staff.

Local EPSDT activities are defined in each county CHDP program plan which includes an interagency agreement negotiated between the local health and welfare agencies. These agreements are developed using uniform guidelines that have been agreed upon by State CHDP Branch and the Social Services Division. The program plans are reviewed by CHDP and Social Services staff for assurance that all EPSDT services are provided as outlined in federal and state regulations. Local agencies do have the option of determining how these activities will be implemented within the State guidelines. State staff provide extensive consultation in development of these plans and agreements.

The State Regional teams, through the county plan, monitor program activities by site reviews, review of program expenditures, review of local program reports, and review of reports generated by the PM 160 (EPSDT Screening/Billing form) from the Child Health Information and Claiming Unit (CHIC Unit). During these reviews, State staff pull records and assist local program staff to identify problems and define solutions with the counties' case management systems.

Budgets

At the time a county submits its annual plan, a budget outlining administrative costs is also submitted. These costs include salaries, wages, and operating costs for the basic implementation of the local program. Budgets are also submitted covering the same costs for implementing the EPSDT Functional Units (Case Management); these costs are matched at 75% FFP. The State general fund allocation to the counties is an exact amount. A county cannot go over this amount. However, the FFP is open ended. This means that if a county wishes to allocate some of its own funds, it can receive matching federal dollars, thus raising the total allocation.

The EPSDT screening costs are paid for out of an account in the Health Care Deposit fund in the State Controller's Office. Disbursements are made by the State Controller upon request from the Department of Health Services Accounting Section. Screening claims are processed through the CHIC Unit as explained below.

Budget and expenditures for diagnosis and treatment services for EPSDT screened children are processed through the Medi-Cal fiscal intermediary, known as Medi-Cal Intermediary Operations (MIO). The current MIO will be replaced by Computer Sciences Corporation in 1980.

Claims and Data Processing

The activities of claims processing and data collection are carried out by the CHIC Unit. This is a special unit formed to process claims and data for the CHDP Program exclusively, and it functions separately from MIO. The 1974 CHDP legislation identified the need for a system that could provide information on the health status of children and gave the option to the Director of the Department of Health Services to devise a system. It was felt that health status of children could not be determined through the regular MIO processing; consequently, the CHIC Unit was formed.

Providers use the PM 160 form to report the health information from the screening encounter and to bill for services. (Attachment #1) This PM 160 is processed manually for apyment by the CHIC Unit. In FY 77-78 the total turn around time stood close to 3-4 weeks, including processing through the CHIC Unit, Accounting Section, and State Controller's Office. An automated payment system is planned for the future, which should reduce the turn-around time while preserving the personal contact between the CHIC Unit and the individual provider, the single greatest strength in the EPSDT claims processing system.

Presently, the data that the CHIC Unit can generate is relatively simple. The CHIC Unit can provide management specialists in the State and County CHDP programs with automated lists of provider names, addresses and types of provider, number of screens, incomplete screens, types of conditions found and screening expenditures. These data are sufficient to meet present federal reporting requirements on the NCSS 120.

The Medi-Cal Program has recently acquired a new fiscal agent. When the automated interface between CHDP/EPSDT and the new Medi-Cal fiscal agent is effected (early 1980), the system will be more streamlined. For the Medi-Cal client receiving a health screen appraisal from CHDP with a referrable condition, the client will be referred/treated with the bill being sent to the Medi-Cal Fiscal Agent. The new fiscal agent, Computer Sciences Corporation (CSC), will then match the diagnosis and treatment services received by the client, with the screen referrable condition recorded via the CHDP billing system. Once the data is matched, a series of reports will be generated by CSC. The reports CSC is committed to provide for EPSDT, in early 1980, appear to meet the future federal EPSDT reporting requirement and thus there will be few areas, if any, that CHDP will either request be changed or added.

Currently, the CHIC Unit is undergoing a difficult period. With the passing of Proposition 13 an automatic hiring freeze occured and the CHIC Unit was prevented from filling vacancies or hiring new staff that has been budgeted. Consequently, a very large number of claims have backed up and a long delay in reimbursement has occurred. There are also delays in collecting and computing the complete data on services rendered during a given quarter.

Provider Recruitment

Based on 1975 data from the American Medical Association, CHDP estimates there were 45,626 licensed physicians in California in 1977, of which 19,605 were primary care physicians (GP/FPs, pediatricians, internists, OB/GYNs). In 1977, 1,388 primary care physicians were enrolled as CHDP providers. Greater detail for pediatricians and family/general practitioners is as follows:

	Total in State	Number Enrolled in Medi-Cal	Number Enrolled in CHDP
FP/GP	7,291	6,219	558
Pediatricians	3,078	1,369	743

Primary responsibility for soliciting and maintaining provider participation in CHDP rests with local CHDP programs. Typical methods for local informing and recruiting include: exhibits at provider conventions, group presentations at medical staff or professional organization meetings, mass mailings, and individual contact by phone and in person. Additional information is given to providers through state efforts, including Medi-Cal Bulletin articles, mailings from the American Academy of Pediatrics and contacts with other provider organizations.

At the local level, provider recruitment is the responsibility of the local CHDP Program Director; actual activities are delegated to a variety of CHDP staff including physicians, public health nurses, health educators and clerks. At the state level, supportive activities in provider recruitment are primarily the responsibility of the Field Operations Section and the Planning and Program Development Section.

In the past, the CMA and AAP have also been involved in the recruitment effort. CMA/AAP/local medical society representatives provided on-going consultation to the state and local level; newsletter articles and mailings on CHDP have occasionally been provided; and CMA/AAP representatives have met with local physicians to discuss CHDP participation.

Although there are state and county procedures to monitor the participation of providers in the program some counties are not doing so on a regular basis. For example, at the time a provider signs an agreement, he is to use the CHDP screening/billing form (PM 160). However, if a provider chooses to bill on the regular Medi-Cal billing form rather than the PM 160 this is not always discovered because the provider performance is not reviewed. Also if local program staff are aware of a provider's deficient performance they are reluctant to inform the provider of the deficiency for fear the provider will withdraw from the program. The local county staff is also reluctant to insist that a provider use a PM 160. The term used by county staffs for this lack of provider supervision was "not rocking the boat".

Reimbursement

The newly adopted CHDP fees are higher than Medi-Cal's for providing history and physical examinations to infants and children and for administering immunizations, but remain below Medi-Cal fees for providing history and physical examinations to adolescents (13-21 years of age), and for vision, hearing and tuberculin testing.

Reimbursement rates have improved considerably since they were established in 1975 and are continually being reviewed and increased as program funds allow. Attachment 2 shows current fees.

Fees are now considered generally competitive with (although not always comparable to) usual provider fees. Fees do not vary for providers in different locations.

Advisory Board

All State CHDP regulation or program changes must be approved by the Child Health Board. This board is mandated by law and consists of eleven members: Four members to be selected by the Legislature; five members selected by the Governor; and two ex-officio members representing the State Departments of Health and Education. Three of the eleven members must be parents of eligible children and one must be a member of a Child Health Advisory group such as the Children's Lobby. The Child Health Board meets in a different county each month and its meetings are open to the public. The Board also serves in an advisory capacity to the State Legislature and the State Health Department. All minutes of the Child Health Board meetings are sent to the Legislature. Similar advisory boards exist at the local level, usually appointed by County Boards of Supervisors, consisting of similar representation and responsibilities.

Local Administration

Each county prepares an annual plan which outlines the process by which the program will be implemented. These plans include the interagency agreement between the public health and welfare departments and the procedure for implementing the federal requirement of informing, screening diagnosis and treatment as well as the case management feature of the program if the county has opted to provide this service. An administrative budget is also included. Finally, the plans are approved by local advisory boards and Boards of Supervisors before they are forwarded to the State for final approval.

Generally the informing, screening, diagnosis and treatment are implemented as follows:

Informing - In all counties the informing activity is done by the welfare department. Initial informing is done at the time of application by the intake workers. The applicant is informed that EPSDT is a service that is available to his children from age 0-21, is given a description of what screening entails and is also informed of the supportive services that are available such as transportation and child care. Question 22 of the WR-2 application form is used to document whether or not an applicant desires CHDP services. In addition California has developed an informing brochure that can be used statewide and meets the federal requirements on informing.

Each applicant receives this brochure at intake. The county welfare departments are also responsible for informing all eligibles once annually in writing. This is done, usually, at the time of redetermination at 3-6 month intervals depending on the case, using the same brochure. The informing brochure has been provided in at least six languages. The most frequently used are the brochures written in English and Spanish.

If an applicant responds with a "yes" answer to question #22 he is informed of the available CHDP providers that can provide the screening service. The applicant selects the provider of his choice and is told that when he becomes eligible he can make his own appointment for screening. If the applicant prefers to be screened by a physician who is not a CHDP provider and is adamant about his choice, the "yes" answer on question #22 is changed to a "no" and no further action is taken, except that the applicant is encouraged to seek the service with the provider of his choice.

Screening - Once an applicant has requested the service and has been determined eligible a screen must occur within sixty days. A screening service can be provided by a variety of providers such as: public health departments, private physicians, hospital clinics, National Health Service Corps, providers, rural health clinics, Comprehensive Family Health Care Centers and Indian Health Clinics. In addition, pediatric nurse practitioners, physician assistants and other physician extenders are used frequently to provide screening services in a variety of public and private settings. There are currently thirteen counties that offer screening services by van. In Los Angeles county there is a private provider who performs all screens in vans. (Attachment #3)

The welfare department staff informs the public health department of all requests for screening and the recipient's choice of provider in addition to any special circumstances that would impact on the recipient's obtaining the screening service. Usually recipients are encouraged to make their own appointments for a screen; however, if the recipient needs assistance in making an appointment the health department staff will assist. The public health department is responsible for following up on all recipients to ensure that a child received the screen. If two contacts are made and the parent has failed to keep an appointment or in essence refuses the service, the case is closed. If there are extenuating circumstances, for example, transportation or child care problems, the health department continues to assist the parent and will coordinate with welfare through social services to resolve the problem.

Once a screening service has been given and the provider completes the PM 160 (Confidential Screening/Billing form) he separates the five part form and sends a copy to the local CHDP program (usually the health department) for follow-up, sends a copy to the CHIC Unit for payment, gives a copy to the parent and keeps a copy for his own record. The copy of the PM 160 that goes to the local CHDP program initiates follow-up for diagnosis and treatment.

Diagnosis and Treatment - The "screening only" provider is responsible for referring the patient for any needed diagnosis and treatment. "Comprehensive countinuous care" providers are also responsible for management of referrals and may do this either by arrangement with the local program or by following their usual practice in this regard, obtaining results of referrals as they do normally. The local CHDP program may assist in referral and follow-up, working with the screening provider, patient, and referral provider as appropriate. In some cases, the local program would be providing information on referrals back to a comprehensive care provider but more usually these providers receive this information as they do for normal referrals. Generally, "screening only" providers, although responsible for making any needed referrals, do not manage referrals and are not informed of the results.

Similarly, the local programs will assist recipients to obtain diagnosis and treatment services.

Case Management:

In July, 1977 the California legislature appropriated the funds that enabled CHDP to begin implementation of the case management function at the local level. EPSDT Functional Units have been established and provide outreach and follow-up services to the Medi-Cal eligible child only. The EPSDT Units also serve to recruit and orient providers to the CHDP program. The State devised a set of uniform guidelines to assist the local program in preparation of a plan. Each county includes in their annual plan a functional statement, staffing pattern and budget for these units and they have also revised the health and welfare interagency agreements to incorporate the case management function. By agreement, the EPSDT Unit may be physically located in either the local health department or the welfare office, but not both.

Presently, there are 39 counties that have qualified for EPDST Functional Unit funding at the 75% FFP matching rate.

The five counties that were reviewed, Alameda, El Dorado, Los Angeles, San Bernardino and San Mateo, all have approved EPSDT Functional Units. Los Angeles County was in the process of transferring the case management function from the welfare department to the public health department. Each county has developed its own procedures. Staff seemed well versed in all procedures; however, the review indicated that their procedures break down at the point of documentation which left gaps in records of continuity of service. It appears that the local programs are not testing their systems at regular intervals to identify possible gaps.

Exemplary Practices:

Two exemplary practices are as follows:

A. In California there are 1,525,747 eligible children which reside in 58 county jurisdictions. Because of the magnitude of the program, California has encountered difficulties in the uniform administration of the program and has continually sought solutions to simplify its administration. In this regard California has developed an administrative tool that provides an orderly, precise and comprehensive presentation of each local program's goals and objectives supported by budgeting and statistical information. Each January the State publishes a CHDP Program Letter which is sent to all County CHDP Directors which requires the following information:

1. Certification Statement - signed by all involved parties that they agree to the plan.
2. Listing of Advisory Board members and their representation, e.g., providers, parent, etc.
3. Summary of previous year's activities.
4. Summary of current fiscal year activities.
5. Projection of Budget year - using management by objectives including problems, unmet needs, objectives, and activities supported by statistics.
6. Actual Budget.
7. Interagency Agreements - must be updated and signed annually.

This entire process is reinforced by technical assistance workshops provided on a regional basis by the Regional State CHDP Consultants. The plans are due in March of each year.

B. The California Child Health Board which is legislatively mandated serves as the State CHDP program's advisory board. This board, described earlier in the report, is representative of providers, consumers, and related health and educational agencies. It is an involved board and serves more than in advisory capacity; it also approves policy. This board is dynamic and it meets monthly in a different area of the State each month. It has been an asset in the sense that it is a forum for all parties involved in the concerns of health care to children, i.e., for input from parents, providers, and CHDP State and local staff.

Positive Practices:

1. The diligence and competent level of performance of the State CHDP staff, especially the Regional Consultants; this includes the staff representing State Social Services.

2. The willingness of the State CHDP Program to implement HEW directives that call for interfacing with other health programs serving children, e.g., Headstart, Immunization Programs, HUD Programs and WIC, etc.

3. Providing Regional training workshops and a system of CHDP Program Letters that serve to provide uniform instruction and clarity.

4. The improvement of procedures and communication by the local County health and welfare agencies.

5. The willingness of local programs to share their "best practice" with others.

Summary of Major Findings & Recommendations

For the purposes of this review HEW staff selected counties that represented the Northern and Southern Regions of the State, urban or rural areas, and those that were isolated or had low health provider resources. The resultant selection was Alameda, El Dorado, Los Angeles, San Bernardino, and San Mateo Counties. It was decided that Los Angeles be included because it represents the largest population of eligibles with 532,118 or 34.87% of the 1,525,747 total EPSDT eligibles; and the largest budget at $1,258,127.50 or 40.24% of the overall $3,126,895 State EPSDT budget; and also has the lowest screening rate in the State of 30,258 or 5.7% of its eligible population. Attachment #4.

Finding: Inadequate Number of Children Screened

From July, 1977 to June, 1978, California reported only 120,990 individuals having recieved complete Medicaid EPSDT screens. This represents less than ten percent of the 1,348,293 target population. Statistics published in Data on the Medicaid Program prepared by the Institute for Medicaid Management (HCFA 78-24523) indicate that for the period October, 1976 to September, 1977, California ranked 51st of the 52 Medicaid jurisdictions reporting in screening their target population. There are several reasons for this, all of which are interrelated.

First, the State currently allows a provider the option of using two billing systems, the CHIC Unit or Medi-Cal, for payment of a screening service as a CHDP screen or as a comprehensive physical, respectively. Many children are thus not being included in the totals for CHDP screens.

Second, the CHIC Unit is improperly counting some screens as incomplete. When a client refuses part of a screen, it should be counted as complete. If a client returns to the provider to complete a previous screen, each service is counted as two incomplete screens if the provider uses two different screening forms. The revised PM 160 which is scheduled for use by April 1979 will offer greater clarity regarding components of the screen which may be contra-indicated at the time the screening takes place.

Third, children are not being appropriately counted as screened due to the inordinate backlog of PM 160s that currently exists in the CHIC Unit. The CHDP Program is experiencing extreme difficulty in automating its claims processing and tracking system. The Department of Finance has cut the FY 79-80 budget by 50%, leaving the Data Managment Branch with only two of the six positions filled. Without this staff, CHDP will not be able to begin the development of the linkage of data from the CHDP CHIC Unit to the data that the Computer Sciences Corporation (CSC) will be providing that will serve to meet the future HEW minimum data sets for EPSDT. These data sets may be required as early as November, 1979.

Fourth, there is presently no way to count children screened in an institutional setting since few hospitals will agree to manually process the PM 160. This problem again impacts on the dual billing situation cited above, since Medi-Cal will accept tape-to-tape bills for comprehensive physicals while the CHIC Unit will only accept the manually processed paper copy of the PM 160.

Recommendations:

There appears to be a real lack of State management commitment to improving the systems through which the PM 160 must pass for final payment. The timely processing of this billing form is crucial, since it documents all requests for EPSDT service, serves as an important public relations conduit between the program and the EPSDT provider, and is the only State-wide mechanism that initiates case management activities related to EPSDT services.

The State's short range systems plan should be to make the current reporting and billing system as efficient and accurate as possible. This includes implementing the new PM 160 on schedule and assuring that the CHDP/CHIC Unit produces the screening paid claims tape and sends this tape to the new fiscal intermediary (CSC) for EPSDT case management reporting. It is recommended that this should be completed by November, 1979. In addition to providing CSC with a paid claims tape, the State should automate check-write for the new PM 160 by July 1, 1979.

The State should develop a procedure to count equivalent comprehensive physicals as complete screens. One way to do this would be to establish a CRVS code for screening/comprehensive physicals that by definition included the required procedures in the screening package. Thus when a provider entered that code on the claim form, he would be stating that the individual received a complete screen or equivalent.

Another way to do this would be to replace the requirement for dual provider agreements, i.e. one for Medi-Cal and one for CHDP, with a requirement that providers must agree to participate in the CHDP program as a condition of participation in Medi-Cal.

The long range plan should be to move all Medicaid EPSDT claims processing and reporting to the new fiscal intermediary. Studies should be made as to the feasibility of using one Medi-Cal claim form for both Medicaid EPSDT screening and treatment services as well as for a child's regular episodic care.

Finding: Proposition 13 Repercussions

Future repercussions regarding Proposition 13 may cause county governments to closely scrutinize the CHDP Program to determine if there are any services performed by the welfare or social services departments which are not currently billed to the CHDP Program. For example, the program receives time from a Medical Consultant (San Mateo), welfare eligibility quality control (LA), and transportation services (LA, San Bernardino and San Mateo). These services may be charged to CHDP in the future.

Recommendation:

It may be to a county's benefit to analyze the extent of support services and overhead which are currently paid by county governments. The State should plan to assume the responsibility for these or find alternatives.

Finding: Inappropriate Funding of County Administrators

Deputy directors of some counties administer other Federal or State programs in addition to EPSDT. In some instances an inappropriate percentage of their salary is budgeted against the EPSDT program. The problem seems to stem from insufficient accounting of the deputy director's time spent on EPSDT as compared to other administrative responsibilities.

Recommendation:

The State should ensure that the personnel budgets of the local CHDP programs only reflect the percentage of time they devote to it.

Finding: Delays in Issuance of Medicaid Eligibility Cards

Delay in provision of eligibility stickers causes delay in the timely provision of screening services. In some counties, it may take a month to obtain an eligibility card, and some providers will not accept patients without them. This situation has a critical effect on newborns who are born at the end of the month, because state policy allows infants to use the mother's eligibility during the month of birth and the month following birth only. The lengthy process in provision of stickers complicates the infants' entry into a tracking system.

Recommendation:

That the State ensure that Medi-Cal cards and stickers be issued on a more timely basis.

Finding: Lack of Basic Program Monitoring

There is a lack of concern with monitoring the provision and quality of care of the health screening. Neither the State regional consultants nor county administrators have devoted adequate attention to reviewing case records for timeliness and completeness of screens. When Los Angeles County pulled records for this review and discovered that two out of sixteen records did not contain a PM 160, county staff were forced to call the parents and physicians to determine if the screening appointment was kept and discovered that the CHDP provider had billed on a Medi-Cal form rather than a PM 160. Counties are not reviewing their case management procedures; many records were not well documented, lacked dates or staff signatures, or failed to indicate the final disposition of the case.

Recommendation:

Case review is the only valid mechanism to determine whether the program is adequately providing timely and complete screens and diagnosis and treatment. Regional consultants and county staff should devote more time to this activity to determine where the gaps exist in the program.

Finding: Use of Regional Consultants

Regional consultants are not consistantly used by the State as liaison with county programs. Their function is not clearly defined nor completely understood nor welcomed by all counties. In some instances Regional staff have had a difference of opinion with the counties regarding state policy. The county goes to the State administration for resolution which may result in a reversal of their own State policy or an exception being made. Situations such as this only serve to aggravate the lack of policy decisions in certain areas of the program and frustrate the efforts of the Regional staff in providing technical assistance.

Recommendation:

The function of the Regional consultants should be clarified with respect to provision of technical assistance and information exchange with the State and among the counties themselves. The State has an obligation to use the Regional staff for its communications with the counties if the consultants are to function as effective liaison.

Finding: Nutritional Component of Screening

The nutritional assessment of the EPSDT Screen can identify nutritional deficiencies, but Medi-Cal does not pay for counseling in this area. In some counties no services at all are available for problems which the screen identifies. Only 26 out of 58 counties have nutritionists on their staff. Approximately 12% of adolescents can be identified as obese, but if there are no referral services available, there is no point in including the nutritional component in the screen.

Recommendation:

That the State should explore with HEW possible methods of reimbursing counties for the services of their nutritionists. It may be possible that nutritional counseling could be absorbed into overhead costs of clinic services.

Finding: Loss of Immunization Data

Some county Health Department Immunization Clinics on follow-up immunizations do not bill on the PM 160 because it is not cost effective in relation to the fee they receive for the immunization. This loss of information for some children results in some repetition of the immunization. Some screens are being counted as imcomplete, and a billing on a form other than the PM 160 means a loss of the immunization record to the CHDP program.

Recommendation:

Ensure that the new PM160 is used for the documentation of immunizations.

Finding: Conflicting Regulations Regarding Transporation

Even though transportation services are theoretically available under the Medi-Cal Program, in actual practice these services are not readily available for purposes of obtaining screening, diagnosis, or treatment services (see the section on transporation contained in the Administration and Management section of this report).

Recommendation:

The State should review its policies and practices regarding transportation and should take corrective action to assure that transportation is available as required in 42 CFR 431.53.

Finding: Report Format Requirements of LA County

Because the county is administered through five districts, all information available from the State regarding the program must be broken out by district if it is to be used by the county. The Data Management and Evaluation Branch has not supplied reports in this format, so LA County, which spends 44% of the State EPSDT budget, cannot use these reports to support their case tracking efforts.

Recommendation:

The State should make information available in a form the counties can use and should keep this in mind when the automated data tracking system is planned.

The following findings refer to situations in specific counties:

Los Angeles

Finding: Lack of Authority over District Offices

The Los Angeles county CHDP director has no direct authority over the five regional health departments that provide CHDP services in Los Angeles county. Although there is constant communication from the county to the outreach unit staff, they are supervised by a Regional Coordinator who has other program responsibilities. The Regional Coordinator is not responsible to the County Director of CHDP, but to the Los Angeles County Director of Public Health. The regions are not obligated to adopt the policy and procedures which the program director advocates. Serious disagreements are brought to the attention of the Deputy Director of the Department of Health Services (DHS). In the past there have been problems regarding physician directors from a specific program directing regional activities. One region refused to cooperate regarding suggested case management practices. There is no written agreement between CHDP and the five regions stipulating responsibilities.

Recommendation:

Discussions should begin with the Director of the Los Angeles County Health Department regarding the feasibility of delegating authority for the local CHDP program from the regional office to the CHDP program. Written inter-regional agreements should be signed to clarify the relationship with the county CHDP program.

Finding: Transfer of Cases

The EPSDT Functional Units' activities were transferred from the Department of Social Services (DSS) to the health department on November 1, 1978. At this time an inordinately large number of clients, who had requested further information about CHDP, were left uninformed about the program. Only one caseworker was assigned to these cases three weeks prior to the transfer of the EPSDT Functional Units. Further delay can be expected because these cases must be distributed among various jurisdictions of the new EPSDT units before informing can begin.

Recommendation:

Immediate distribution of cases to the EPSDT Functional Units should be undertaken to begin the outreach process.

Finding: Lack of Interest in Monitoring

The present interagency agreement between DSS and DHS calls for an "audit system" to be developed and in place by March 30, 1979. The lack of agreement to a common audit of the program by Health and DSS reportedly delayed the transfer of the outreach EPSDT Functional units to the DHS. This attitude is consistent with the Department's past reluctance to pull casses for monitoring to insure completeness of screens and tracking to service.

Recommendation:

The terms of the Los Angeles County CHDP program's Interagency Agreement with DSS should be implemented immediately.

San Bernardino

Finding: Scarcity of Providers

The county lacks adequate providers in some rural areas. This problem is complicated by large numbers of CHDP providers who routinely bill Medi-Cal.

Recommendation:

Increased provider recruitment and provider education is called for.

Finding: Incomplete Case Records

Incomplete screens were found without adequate explanation. Recent centralization of the program at the county level has improved the situation as shown by increasing documentation and completeness of screens from the first to the fourth quarters of FY 1977-78.

Recommendation:

The local program should continue reviewing cases for documentation and completeness.

San Mateo

Finding: Inadequate Training of Eligibility Workers

Eligibility workers in Social Services were receiving inadequate training regarding the CHDP program. Training was limited to one hour during general orientation to the AFDC program. One additional visit had been made to DSS for retraining, but the eligibility workers had a limited amount of time to participate. Those outreach workers interviewed felt that more training was needed to maintain interest in the program.

Recommendation:

A provision for retraining should be included as part of the interagency agreement. Consideration could be given to rotating eligibility workers from Social Service into the EPSDT units. This would provide training and first hand experience with the CHDP program.

Finding: Case Management

During records review, several cases were found to be incomplete without adequate documentation. A general lack of clarity regarding the screening provisions was evident during provider interviews. It appeared that the county may have enrolled providers without ensuring the responsibilities were completely understood.

The county feels that it is their responsibility to provide a case tracking system which ensures that every child reaches the screen and the needed treatment. The tracking system which the county has developed is fully able to do this. However, further provider education is called for regarding the completeness of screening components.

Recommendation:

San Mateo county must reinforce provider education regarding the completeness of screens.

Alameda

Finding: Lack of Health Management and Administrative Support

A review of PM 160 and case management documentation revealed incomplete screens and a general lack of continunity in documenting the diagnosis and treatment phase of case management. These deficiencies occurred almost exclusively at the public health department level which has only two half time Public Health Nurses monitoring the management of cases and performance of providers.

Recommendation:

The local program must take immediate steps to monitor all PM 160s and the cases management activities more closely. More staff, especially PHNs, must be hired to carry out the monitoring function.

STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY

ATTACHMENT 1

DEPARTMENT OF HEALTH

CONFIDENTIAL SCREENING/BILLING REPORT

California Child Health and Disability Prevention Program

CHDP I.D. NUMBER

PATIENT'S NAME (LAST) (FIRST) (M.I.)

MEDI-CAL I.D. NUMBER

CHECK IF PHP ENROLLEE ☐

RESPONSIBLE PERSON'S ADDRESS (STREET) (CITY) (ZIP)

PHONE NUMBER

PATIENT'S COUNTY OF RESIDENCE

PATIENT'S BIRTHDATE Mo. Day Yr.

PATIENT'S SEX Male ☐ ☐ Female

SEHS Initial ☐ ☐ Periodic

NEXT VISIT Mo. Yr.

PATIENT'S ETHNIC ORIGIN

☐ White	☐ Black	☐ Japanese	☐ Filipino
☐ Mex. Amer.	☐ Chinese	☐ Amer. Indian	☐ Other

ELIGIBILITY

For Medi-Cal reimbursement, attach POE label here. For CHDP reimbursement, the following statement must be signed:

I have read and understand the criteria for CHDP eligibility. This is to certify that the above-named patient is not a Medi-Cal recipient and is ☐ or is not ☐ *(check one)* eligible for CHDP reimbursement.

► SIGNATURE OF PARENT OR GUARDIAN

DATE

Check one outcome column for each procedure. →

	PROCEDURE	NO SIGNIFICANT ABNORMALITY 1	SUSPECTED CONDITION: FOLLOW-UP BY SCREENING PROVIDER KNOWN 2	NEW 3	SUSPECTED CONDITION: TO BE REFERRED KNOWN 4	NEW 5	NO FOLLOW-UP 6	NOT GIVEN 7	REFUSED 8	Comments	FEE $ ¢
SEHS	Health and Development History (01)										SEHS
	Physical Exam (02)										
	Blood Pressure Systolic (03) ☐ mm/Hg Diastolic (04) ☐										
	Dental Assessment (05)										
	Nutrition Evaluation (06)										
	Measurements Height (07) inches ☐ Weight (08) lbs. ☐ ☐ oz.										
TESTS	Vision Screening (09) Snellen ☐ ☐ MCT										VISION
	Audiometric Screening (10)										AUDIO
	Tuberculin (12) Tine Type ☐ ☐ PPD										TB
	Laboratory Hemoglobin (13) ☐ 1/10g or Hematocrit (14) ☐ %										HGB/HCT
	Urine Dipstick (15)										URINE

PROVIDER DATA

PATIENT SEEN Mo. Day Yr.

PROVIDER'S COUNTY OF RESIDENCE

PROVIDER'S SOCIAL SECURITY NO. OR FEDERAL TAXPAYER'S NO.

PROVIDER OF SERVICE

NAME/ADDRESS/PHONE NO.

PROVIDER NUMBER

This is to certify that the screening information is true and complete, and the results explained to the child or his parents or guardian. I understand that payment and satisfaction of this claim may be from Federal and State funds, and that any false claims, statements or documents or concealment of a material fact, may be prosecuted under applicable Federal or State law.

► SIGNATURE OF PROVIDER

DATE

DIAGNOSIS AND/OR TREATMENT Initiated this visit ☐ ☐ Scheduled to be done by screening provider

See Instructions on back.

IMMUNIZATIONS

Type	Up to Date 1	Given 2	Still Need 3	Total Since Birth 4	FEE
DPT (40)					
DT (41)					
Polio – Oral (42)					
Rubella (43)					
Measles (44)					
Mumps (45)					

TOTAL FEES ►

PM 160 (10-75)

① os

STATE DEPT. OF HEALTH

E OF CALIFORNIA—HEALTH AND WELFARE AGENCY

DEPARTMENT OF HEALTH

CONFIDENTIAL SCREENING/BILLING REPORT

California Child Health and Disability Prevention Program

CHDP I.D. NUMBER

NT'S NAME (LAST) (FIRST) (M.I.)

MEDI-CAL I.D. NUMBER

CHECK IF PHP ENROLLEE ☐ 1

RESPONSIBLE PERSON'S ADDRESS (STREET) (CITY) (ZIP)

PHONE NUMBER

PATIENT'S COUNTY OF RESIDENCE

NT'S BIRTHDATE Mo. Day Yr.

PATIENT'S SEX: Male 1 2 Female

SEHS: Initial 1 2 Periodic

NEXT VISIT Mo. Yr.

NT'S ETHNIC ORIGIN

☐ White ☐ Black ☐ Japanese ☐ Filipino

☐ Mex. Amer. ☐ Chinese ☐ Amer. Indian ☐ Other

ELIGIBILITY

For Medi-Cal reimbursement, attach POE label here. For CHDP reimbursement, the following statement must be signed:

I have read and understand the criteria for CHDP eligibility. This is to certify that the above-named patient is not a Medi-Cal recipient and is ☐ or is not ☐ *(check one)* eligible for CHDP reimbursement.

▶

SIGNATURE OF PARENT OR GUARDIAN

DATE

C…k one outcome column for …h procedure. ⟶

PROCEDURE	NO SIGNIFICANT ABNORMALITY 1	SUSPECTED CONDITION: FOLLOW-UP BY SCREENING PROVIDER KNOWN 2	 NEW 3	SUSPECTED CONDITION: TO BE REFERRED KNOWN 4	 NEW 5	NO FOLLOW-UP 6	NOT GIVEN 7	REFUSED 8	Comments	FEE $ ¢
Health and Development History (01)	1	2	3	4	5	6	7	8		SEHS
Physical Exam (02)	1	2	3	4	5	6	7	8		
Blood Pressure Systolic (03) mm/Hg Diastolic (04)	1	2	3	4	5	6	7	8		
Dental Assessment (05)	1	2	3	4	5	6	7	8		
Nutrition Evaluation (06)	1	2	3	4	5	6	7	8		
Measurements Height (07) inches Weight (08) lbs. oz.	1	2	3	4	5	6	7	8		
Vision Screening (09) Snellen 1 2 MCT	1	2	3	4	5	6	7	8		VISION
Audiometric Screening (10)	1	2	3	4	5	6	7	8		AUDIO
Tuberculin (12) Tine Type 1 2 PPD	1	2	3	4	5	6	7	8		TB
Laboratory Hemoglobin (13) 1/10g or Hematocrit(14) %	1	2	3	4	5	6	7	8		HGB/HCT
Urine Dipstick (15)	1	2	3	4	5	6	7	8		URINE
	1	2	3	4	5	6	7	8		
	1	2	3	4	5	6	7	8		
	1	2	3	4	5	6	7	8		
	1	2	3	4	5	6	7	8		

PATIENT SEEN Mo. Day Yr.

PROVIDER'S COUNTY OF RESIDENCE

PROVIDER'S SOCIAL SECURITY NO. OR FEDERAL TAXPAYER'S NO.

DIAGNOSIS AND/OR TREATMENT: Initiated this visit 1 2 Scheduled to be done by screening provider

PROVIDER OF SERVICE

PROVIDER NUMBER

NAME/ADDRESS/PHONE NO.

See Instructions on back.

IMMUNIZATIONS

Type	Up to Date 1	Given 2	Still Need 3	Total Since Birth 4	
DPT (40)	1	2	3		
DT (41)	1	2	3		
Polio – Oral (42)	1	2	3		
Rubella (43)	1	2	3		
Measles (44)	1	2	3		
Mumps (45)	1	2	3		

This is to certify that the screening information is true and complete, and the results explained to the child or his parents or guardian. I understand that payment and satisfaction of this claim may be from Federal and State funds, and that any false claims, statements or documents or concealment of a material fact, may be prosecuted under applicable Federal or State law.

▶

SIGNATURE OF PROVIDER

DATE

TOTAL FEES ▶

PM 160 (10-75)

① OSP

STATE DEPT. OF HEALTH

ATTACHMENT #2

6868. Schedule of Maximum Allowances.

(a) Health screening procedures. Reimbursement for the procedures listed in this subsection, when billed in accordance with this subchapter, shall be the amount billed by the provider for the procedures performed, up to the maximum allowances specified in this subsection. For purposes of this subsection: new patient means a person who has not previsouly received a child health and disability prevention screen from the examiner, and there is no child health and disability prevention screening record established with the provider; extended visit means a visit in which the patient requires as much or more time to be screened as does a new patient; routine visit means a visit in which the patient requires less time than ordinarily needed with a new patient or an extended visit.

HEALTH SCREENING PROCEDURES	MAXIMUM ALLOWANCES
History and Physical Examination by comprehensive care provider	
new patient or extended visit	$30.30
routine visit	22.40
by other screening provider	
new patient or extended visit	25.60
routine visit	20.30
Vision Screening	
Snellen Eye Test or equivalent	1.50
Modified Clinical Technique (MCT)	2.80
Hearing Screening	
Pure Tone Audiometry	3.60
Tuberculin Testing	
Multiple Puncture	1.50
Mantoux (intracutaneous)	3.60

(b) Laboratory Tests. For laboratory tests listed in this subsection that the provider performs, reimbursement shall be either the provider's usual charge to the general public for the test or the maximum allowance specified in this subsection, whichever is less. If a laboratory test is performed by other than the screening provider, for instance by an outside laboratory, the screening provider may bill the Department's Child Health and Disability Prevention Program for the charge made to the provider by the laboratory, plus a charge not to exceed $3.46 for the provider's collection and handling of the specimen. The total shall not exceed the maximum allowance specified in this subsection for the laboratory test. Whether performed by the provider or an outside laboratory, clinical laboratory tests shall be performed in the manner and by persons and laboratories that meet the relevant standards established in the Health and Safety Code, the Business and Professions Code and Title 17 of the California Administrative Code.

LABORATORY TESTS	MAXIMUM ALLOWANCES
Blood Tests	
Hematocrit	$ 2.25
Hemoglobin	2.25
Sickle Cell Status (Electrophoresis)	14.00
Blood Lead Screening	
Free Erythrocyte Protoporphyrin (FEP)	5.60
Blood Lead Level Determination (if FEP positive)	16.80
Test for Syphilis	
VDRL (Venereal Disease Research Laboratory)	3.40
RPR (Rapid Plasma Reagin)	3.40
ART (Automated Reagin Test)	3.40
Phenylalanine (PKU) Blood	3.40
Urine Tests	
Urine "Dipstick"	2.15
Tests for Microorganisms	
Culture for Neisseria Gonorrhea	4.50
Cytologic Tests	
Papanicolaou (Pap) Smear	8.40

(c) Immunizations. Reimbursement for the immunizations listed in this subsection, when billed in accordance with this subchapter, shall be the amount billed by the provider for the immunizations given, up to the maximum allowances specified in this subsection. The maximum allowance includes the cost of the immunizing agent.

IMMUNIZATIONS	MAXIMUM ALLOWANCES
DPT (diphtheria and tetanus toxoids with pertussis vaccine)	
First of series	$ 5.12
Second of series	5.12
Third of series	5.12
Booster	5.12
Td (combined tetanus and diphtheria toxoids, adult type)	5.12
TOPV (trivalent oral polio virus vaccine)	
First of series	$ 5.12
Second of series	5.12
Third of series	5.12
Booster	5.12
Measles vaccine	6.00
Rubella vaccine	6.00
Mumps vaccine	6.00
MR (measles, rubella) vaccine	10.00
MMR (measles, mumps, rubella) vaccine	12.00
MuR (mumps, rubella) vaccine	10.00

NOTE: Authority cited: Sections 208 and 321 of the Health and Safety Code. Reference: Sections 323 and 323.2 (a), Health and Safety Code.

SCREENING VANS DELIVERING EPSDT SERVICES

ATTACHMENT # 3

There are 17 screening vehicles currently in use within the State of California.

The local programs listed below have screening vehicles in use providing CHDP screening services. Also listed are the staffing patterns typically associated with the use of these vans.

COUNTY	STAFFING PATTERNS	
Los Angeles (2)	Currently on Order	
Kern (1)	Currently on Order	
Contract Counties	1 - Public Health Nurse Examiner 1 - P.H. Assistant (Clerk/Driver)	1 - R.N. or PHN 1 - Volunteer
Inyo	1 - Pediatric Nurse Associate	1 - Licensed Vocational Nurse or R.N.
Madera	1 - PNA 1 - Lab. Aide	1 - R.N. 1 - Clerk
Merced	1 - PNA 2 - Community Health Aides	1 - PNA or MD
Monterey	1 - MD	1 Health Aide (Driver)
Plumas	1 - Pediatric Nurse Practitioner 1 - Clerk	1 - LVN
Riverside (2) "Desert" & "City"	2 - Nurse Practitioners 1 - Community Service Aides 0-1 - Referral Nurse	1 - Clinic Nurse 1 - Clerk
Sacramento	1 - PNP 1 - MD	1 or 2 PHN 2 - Public Health Aides (Driver/Clerk)
San Bernardino (2) "Desert"	1 - PHN Assessor or MD 2 - Nurse Practitioners	2 Public Health Workers 1 or 2 Clinic Nurses
"School"	2 - Nurse Practitioners 2 - Community Health Workers	1 Clinic Nurse 1 School Person
San Luis Obispo	1 or 2 PHN Assessors 1 - Clerk	1 - Health Aide
Shasta	1 - Nurse Practitioner	1 - R.N.
Solano	1 or 2 Nurse Practitioners 1 - R.N. 1 - Driver	1 - Community Aide 1 - Clerk
Stanislaus	2 - PHN Assessors	1 or 2 Health Aides
Tulare (2)	1 - PNA 1 or 2 Health Aides	1 - Nurse Assessor 1 - LVN

Purchase of Screening Vehicles
Child Health and Disability Prevention Program
Policy and Guidelines

Policy: The local community CHDP Program must be able to demonstrate significant benefits to their overall program prior to the authorization of resources for the purchase of screening vehicles and medical equipment.

Screening Vehicle -- Any mobile unit whether self contained van, truck or trailer and such equipment necessary to pull the trailer. Note: The vehicle(s) must comply in every respect with the requirements and regulations of the Department of Housing and Community Development, and of the Department of Motor Vehicles of the State of California.

Medical Equipment -- Any equipment purchased for use in the screening vehicle for the performance of CHDP screening services not to include such minor equipment defined as equipment under $150 and life expectancy of under two years and/or practitioner's equipment such as sphygmometer, opthalmoscope, otoscope, pen light, tuning fork, etc., and disposable supplies such as tongue blades, sytringes, etc.

1. The local community CHDP Program shall demonstrate that the screening activities will be usbstantially increased and/or the quality enhanced in the County with the use of the vehicle and medical equipment.

2. The local community CHDP Program shall develop a protocol for the use of the vehicle. They shall address the following:

SCREENING VANS DELIVERING EPSDT SERVICES ATTACHMENT # 3

There are 17 screening vehicles currently in use within the State of California.

The local programs listed below have screening vehicles in use providing CHDP screening services. Also listed are the staffing patterns typically associated with the use of these vans.

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Madera	1 - PNA 1 - Lab. Aide	1 - R.N. 1 - Clerk
Merced	1 - PNA 2 - Community Health Aides	1 - PNA or MD
Monterey	1 - MD	1 Health Aide (Driver)
Plumas	1 - Pediatric Nurse Practitioner 1 - Clerk	1 - LVN
Riverside (2) "Desert" & "City"	2 - Nurse Practitioners 1 - Community Service Aides 0-1 - Referral Nurse	1 - Clinic Nurse 1 - Clerk
Sacramento	1 - PNP 1 - MD	1 or 2 PHN 2 - Public Health Aides (Driver/Clerk)
San Bernardino (2)		
"Desert"	1 - PHN Assessor or MD 2 - Nurse Practitioners	2 Public Health Workers 1 or 2 Clinic Nurses
"School"	2 - Nurse Practitioners 2 - Community Health Workers	1 Clinic Nurse 1 School Person
San Luis Obispo	1 or 2 PHN Assessors 1 - Clerk	1 - Health Aide
Shasta	1 - Nurse Practitioner	1 - R.N.
Solano	1 or 2 Nurse Practitioners 1 - R.N. 1 - Driver	1 - Community Aide 1 - Clerk
Stanislaus	2 - PHN Assessors	1 or 2 Health Aides
Tulare (2)	1 - PNA 1 or 2 Health Aides	1 - Nurse Assessor 1 - LVN

Purchase of Screening Vehicles
Child Health and Disability Prevention Program
Policy and Guidelines

Policy: The local community CHDP Program must be able to demonstrate significant benefits to their overall program prior to the authorization of resources for the purchase of screening vehicles and medical equipment.

Screening Vehicle -- Any mobile unit whether self contained van, truck or trailer and such equipment necessary to pull the trailer. Note: The vehicle(s) must comply in every respect with the requirements and regulations of the Department of Housing and Community Development, and of the Department of Motor Vehicles of the State of California.

Medical Equipment -- Any equipment purchased for use in the screening vehicle for the performance of CHDP screening services not to include such minor equipment defined as equipment under $150 and life expectancy of under two years and/or practitioner's equipment such as sphygmometer, opthalmoscope, otoscope, pen light, tuning fork, etc., and disposable supplies such as tongue blades, sytringes, etc.

1. The local community CHDP Program shall demonstrate that the screening activities will be usbstantially increased and/or the quality enhanced in the County with the use of the vehicle and medical equipment.

2. The local community CHDP Program shall develop a protocol for the use of the vehicle. They shall address the following:

a. How many additional CHDP screens will be provided by your program per month? For the year?

b. Which other program services will be integrated (immunization, WIC, CHC's) with the use of the vehicle.

c. What areas and what target groups will be served; how are these areas and target groups currently being served.

d. Which local program personnel will be responsible for the vehicle; what provisions for storage maintenance will be made.

e. What arrangements will be made to train staff for the operation of the vehicle.

f. What changes in current staff assignments will be required including identifying which staff (classifications) and the appropriate number of person hours per month.

g. If additional staff will be required for the operation of the vehicle, what classification will be needed, how will they be funded and what are the appropriate number of person hours per month.

h. What is the estimated usage (number of days per month) for CHDP screening for other related programs.

3. The local program shall develop their own mechanism to document the use of the screening vehicle according to the County's written policies and procedures. It should provide a performance and fiscal audit trail acceptable to the State Department of Health Services.

4. The operating expenses including costs for Personnel and maintenance, insurance, and medical supplies should be drawn from screening revenues not from program allocation funds.

5. Competitive bidding must be secured. If the County has a competitive bid procedure then that procedure must be followed for the purchase of the screening vehicle and the medical equipment. Specifications to be used in that bidding procedure should be developed jointly by the State and the local Community program.

ATTACHMENT #4

STATISTICS ON ASSESSED COUNTIES

Eligibles/Screens

Total Medical Eligibles in State = 1,525,747

County	Medi-Cal Eligibles	% of State Eligibles	Number Screened	% of Total *
Alameda County	60,164	3.94%	6,202	11.2%
Berkeley	4,182	0.27	473	11.3
El Dorado	2,768	0.18	706	25.5
Los Angeles	532,118	34.87	30,258	5.7
San Bernardino	53,763	3.52	9,634	17.9
San Mateo	14,765	0.97	6,202	42.0
TOTAL	667,760	43.75%	54,042	

* The percentage of screens ranged from 5.7% in Los Angeles County to 42% in San Mateo. The percentage of screens for the five counties combined is 8.1%.

EPSDT EXPENDITURES

Total State EPSDT Budget = $3,126,895.

Counties	Budget	% of Total
Alameda	$ 177,165.00	5.67%
El Dorado	4,648.00	0.15
Los Angeles	1,258,125.50	40.24
San Bernardino	129,327.00	4.14
San Mateo	54,565.00	1.75

REGION IX

DEPARTMENT OF HEALTH, EDUCATION AND WELFARE

HEALTH CARE FINANCING ADMINISTRATION

MEDICAID BUREAU

Utilization Control

CALIFORNIA STATE ASSESSMENT

October 16-27, 1978

Participants:	Lankford Williams (RO/Medicaid) Rozanne Brazil (CO/Medicaid) Lois Seidler (RO/HSQB) Bill Herndon (RO/Medicaid) Mickey McManus (CO/Medicaid)

UTILIZATION CONTROL - STATE OF CALIFORNIA

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CALIFORNIA UTILIZATION CONTROL

Overview

The Utilization Control area of the California Medicaid program (Medi-Cal) was reviewed October 16-27, 1978. The five member Federal review team was comprised of Regional Office Medicaid Bureau and Health Standards and Quality Bureau staff, and Central Office Medicaid Bureau staff. Review areas primarily included:

1) The State's waivered utilization review system;
2) Authorization of payment mechanisms;
3) Medical Review/Independent Professional Review activities;
4) Interface with Professional Standard Review Organizations (PSRO).

During the two-week review period, team members made visits to the following sites:

- Field Services Section Headquarters
- Seven Medi-Cal Field Offices
- One Fiscal Intermediary
- Seven Long-Term-Care Facilities
- Three Mental Hospitals (State and Private)
- Five Acute Care Hospitals
- Two PSROs
- One Pilot Project (Fresno/Madera)

Utilization control activities are carried out through the Field Services Section, Operations Branch, Medi-Cal Division, Department of Health Services. There are twelve (12) field offices. Each field office is an autonomous unit, performing all utilization control functions in the area under its purview. The field office staffs include administrative personnel, physician consultants, and registered nurses. Most of the field offices have a social service consultant (SSC); however, in a few areas the SSC is shared by two offices. Each field office administrator supervises field office staff and reports to the Field Services Section at the State level.

Waivered System

The State of California operated under a Utilization Review (UR) waivered system until 1977, at which time decisions were made by DHEW on waiver requests at all levels of care except the Intermediate Care Facility (ICF) level. (ICF level of care UR could not be waived). The waiver for Acute Hospitals covers all areas of the state except the Los Angeles County Acute Hospital system, special project areas and those under PSRO. This waiver has not been approved by HEW and cannot be continued beyond December 1, 1978 for hospitalizations in areas where conditional PSROs are prepared to assume review quickly and perform 100% preadmission review for the first 6 months. In the remainder of the State, this system can be used until January 30, 1979. The waiver at the Skilled Nursing Facilities level was granted conditional approval by HEW for a period of 12 months beginning June 30, 1977. This was subsequently extended until December 15, 1978. For the Mental Hospitals, conditional approval was granted through July 31, 1979.

Medical Review/Independent Professional Review

Title XIX recipients in long-term-care (LTC) facilities are reviewed annually by the field office medical review teams. However, the social service component of the medical review (MR) process is weak due to an inadequate number of social workers to handle the workload.

Prior Authorization

The Prior Authorization system in California consists of a rather detailed process which requires review and approval by a Medi-Cal consultant of the Treatment Authorization Request form (TAR) as submitted by a provider in advance of the rendering of a service. Prior authorization is required for the majority of services provided by the Medi-Cal program.

Professional Standards Review Organizations (PSRO)

The State of California has 28 designated PSRO areas. There are presently 23 conditional PSROs and 5 in planning status. Only nine of the 23 conditional PSROs have been able to successfully negotiate Memorandums of Understanding (MOUs) with the State and implement Title XIX review as required by Section 1155(a)(1) of the Social Security Act.

Areas of Concern

The State has made a serious attempt to operate a very complicated program in a cost effective manner. The Single State Agency, however, needs to take a critical look at the following areas for improvement:

1. Written criteria for admissions and continued stay

2. Medical Care Evaluation Studies (MCEs)

3. Special Projects and Subsystems

4. State Operated Facilities
5. Medi-Cal funded positions in State Hospitals
6. Interface with Professional Standard Review Organizations

Throughout the State Assessment, federal review team members noted inconsistencies among field offices in the application of California's utilization control processes. This situation is due in part to the fragmentation resulting from having 12 autonomous field offices. Supervision and control from the Field Services Section in Sacramento appears difficult. Specific concerns are discussed in detail in the findings and recommendations section of this report.

The State's Waivered Utilization Review System

In an amendment to the Social Security Act, Congress required State Medicaid agencies to adopt the same UR system used under Medicare (Title XVIII). Provisions were included in Section 1903 to waive this requirement if certain conditions were met. The waiver provision provides for an alternative UR system, but requires documentation from the State which demonstrates, to the Secretary's satisfaction, the superiority in effectiveness of the State alternative UR procedures to the Title XVIII method of UR. The Secretary could, but was not required to, grant a waiver under this provision. Until 1977 the Department of Health Services (DHS) operated under a waivered system, with numerous subsystems, at all levels of care except the ICF level which could not be waived. It was difficult to determine which subsystem in the California waiver request was superior in effectiveness to the Federal requirement. In 1977 decisions were made by DHEW on waivers for all levels of care as described below.

Utilization Review Waivers

Acute Hospitals

The system described below is being utilized in all areas of the State except those covered by the Los Angeles County Hospital system, the Fresno/Madera and Redwood special projects, and the hospitals under review by nine (9) PSROs (Redwood Coast Region PSRO, Greater Sacramento Area PSRO, San Joaquin Area PSRO, Santa Clara Valley PSRO, Monterey Bay Area PSRO, Kern County PSRO, Inc., Organization for PSRO of Santa Barbara - San Luis Obispo Counties, California PSRO Area 23, and Riverside County PSRO).

I. Description of System

A. Admission Review

All non-emergency admissions require prior authorization from a Field Office Medi-Cal Consultant for a specified number of days. Emergency admissions do not require prior authorization, however a statement from the admitting physician describing the emergency is required. This covers the first three days of an emergency admission and is reviewed by the Medi-Cal Intermediary Operation (MIO) under the post-service, pre-payment audit system.

B. Continued Stay Review

Non-emergency admissions beyond the previously approved number of days and emergency admissions beyond three days require prior approval for extension. In the majority of cases, these extensions are approved on-site (in the hospital) by Medi-Cal RNs. All decisions in questioned cases, denials, reductions of length of stay, and reductions in level of care are made by Medi-Cal physician consultants.

II Present Status

The State agency was informed in a letter from Health Standards and Quality Bureau Regional Office dated September 6, 1978, that this system has not been approved by HEW and cannot be continued beyond December 1, 1978 for hospitalizations in areas where conditional PSROs are prepared to assume review quickly and perform 100% preadmission review for the first 6 months. In the remainder of the State, this system can be used until January 30, 1979.

Findings and Recommendations - Acute Hospitals

1. Finding - Written Criteria Unavailable

Written criteria for the medical necessity of admissions and continued stay are not available. Medi-Cal consultants (MD and RN) are primarily using professional judgment in making these decisions. Without written criteria, consistency in determinations cannot be ensured.

Recommendation:

Written criteria should be utilized by Medi-Cal consultants during the period in which the State's present utilization review system continues to be in effect. Medi-Cal consultants should document in their decisions and deferrals how criteria was or was not met and communicate this to the physician requesting the admission.

2. Finding - Length of Stay Standards

Although a schedule for hospital lengths of stay is provided in the California Administrative Code, Title 22, Section 51327, the Medi-Cal physician consultants interviewed stated that the Code was outdated and they were using their own revisions as a guide.

Recommendation:

The length of stay standards being used by the Medi-Cal consultants and those in the Code should be brought into agreement.

3. Finding - Quarterly Monitoring of Medi-Cal Consultants

The quarterly monitoring of field office consultants' (RNs and MDs) activities by senior Medi-Cal consultants from the Medi-Cal Benefits Section has not been performed in the past three quarters, or longer. The purpose of the monitoring is to ensure uniform and appropriate application of Medi-Cal regulations and standards. A memorandum dated 9/18/78 from the Medical Care Standards Division indicated the reviews would begin 9/27/78. At the time of the State Assessment, the activity was already one month behind schedule.

Recommendation:

> The State should begin regular quarterly field office reviews, and should adhere to the schedule attached to the memorandum dated 9/18/78. Following completion of this schedule, the State should continue regular quarterly reviews.

4. Finding - Medical Care Evaluation Studies (MCEs)

MCEs are not being required under the present State utilization review system, although they are required by 42 CFR 450.19. In those hospitals visited, Medi-Cal patients were being included in the MCEs being conducted due to PSRO and/or JCAH requirements, but not because the facility personnel understood it to be a Title XIX requirement.

Recommendation:

> MCE studies which include Medi-Cal patients must be required by the State and must be conducted in acute hospitals during the period in which this system continues to be in effect.

Los Angeles County Acute Hospital System

The waiver requested for the utilization review system used by the Los Angeles County acute hospital system was denied in a January 5, 1978 letter from HEW. Those seven hospitals (Long Beach General Hospital, Rancho Los Amigos Hospital, Los Angeles County Harbor - UCLA Medical Center, Olive View Medical Center, and Mira Loma General Hospital) are no longer under a waiver and are to conduct utilization review in compliance with 42.CFR 450.19 or under a PSRO system. Compliance with this requirement is being assessed and monitored by the State Survey Agency as part of the periodic survey process.

Skilled Nursing Facilities

The system described below is being utilized in all areas of the State except those covered by the Fresno/Madera and Redwood special projects.

I. Description of System

A. Admission Review

All admissions require prior authorization from a Field Office Medi-Cal consultant (RN or MD). Medicare/Medi-Cal covered beneficiaries and emergency cases require authorization following admission for continued stay beyond Medicare coverage.

B. Continued Stay Review

Reauthorization by a Medi-Cal consultant (RN or MD) and recertification by the attending physician is required every 60 days for all patients not classified as "prolonged".

Annual reauthorization by a Medi-Cal consultant and recertification by the attending physician every 60 days is required for all "prolonged" patients meeting specified criteria.

Periodic medical review is conducted by a field office team at least annually. (See MR/IPR section of this report for details.)

II. Present Status

HEW granted conditional approval of California's request for a waiver for a period of 12 months beginning June 30, 1977. This was extended until December 15, 1978, to provide time for on-site visits to be made by HEW Regional Office staff to determine compliance with the conditions of the waiver.

Findings and Recommendations - Skilled Nursing Facilities

1. Finding - Prolonged Care Criteria

Although the Medi-Cal nurse consultant is usually the one conducting evaluation of patients prior to determining prolonged care status, documentation of this evaluation frequently does not reflect the use of established prolonged care criteria. Most of the Medi-Cal nurse consultants interviewed were either unaware of, or not conversant with, the established criteria.

Recommendation:

> Either through training and/or written communication, Medi-Cal consultants should be informed of the prolonged care criteria and the need to apply it. The application of the criteria should be clearly documented when these determinations are made.

2. Finding - Medical Care Evaluation Studies (MCEs)

Although the Medi-Cal patients were included in MCEs being conducted in Title XVIII-XIX Skilled Nursing Facilities visited, the Staff denied ever having been informed that this was a Medi-Cal requirement. Rather, the studies were being performed as a Title XVIII requirement and all patients in the facilities were being included to provide a better data base.

Title XIX-only SNFs have not been required to perform MCEs by the State, although that requirement was a condition of the waiver granted in June, 1977. A memorandum was sent by the State to these SNFs on August 13, 1978, imposing the MCE requirement effective October 31, 1978.

Recommendation:

Title XVIII-XIX SNFs should be informed clearly that MCEs which include Medi-Cal patients must be performed as a requirement of the Medi-Cal program. Instructions which will improve the quality of the studies currently being performed would also be helpful.

The MCE process described in the August 13, 1978, memorandum to Title XIX SNFs should be monitored closely to assure that the MCE requirements are met.

Mental Hospitals

I. Description of System

A. Prior Authorization

All non-emergency admissions to mental hospitals require prior authorization (TAR) from a Field Office Medi-Cal consultant for a specified number of days. The request form must include adequate information and justification for the specified period of hospitalization needed for the patient. Emergency admissions do not require prior authorization. A statement from the admitting physician describing the emergency covers the first 72 hours of the admission.

B. Concurrent Review

Non-emergency admissions beyond the previously approved number of days and emergency admissions beyond three days require prior approval for extension. The Medi-Cal consultants responsible for approving or denying TARS are RNs and MDs. The MDs, in most cases, are not psychiatrists. The concurrent reviews are performed when the initial authorized period expires and periodically thereafter, if the patient remains beyond the expiration of subsequent authorizations.

II. Present Status

The State Agency was informed in a letter dated August 10, 1978, that as a result of an assessment of documentation presented by the DHS and on-site visits conducted by Medicaid staff, HCFA-Region IX, conditional approval was granted to the request for a waiver of utilization review requirements of Section 1903(i)(4) in Mental Hospitals. This conditional approval through July 31, 1979 is contingent upon compliance with conditions as specified below:

1. *Written criteria for admission and continued stay must be provided and used in all District Offices and in provider facilities where UR is conducted.*
2. *Senior Medi-Cal consultants must conduct the quarterly monitoring review of field offices as indicated in the description of the utilization control program in California.*
3. *Utilization review responsibility is to be transferred to the PSRO in the respective area when HEW determines the PSRO is prepared to assume the responsibility.*

III. Medical Reviews

Annual Medical Reviews are conducted as required. The on-site team leader is always an MD or RN having experience with the care and treatment of mental illness. However, the MD in most cases, is not a psychiatrist.

Findings and Recommendations - Mental Hospitals

1. Finding - State Agency has not made MCEs a requirement

In private mental hospitals, Medical Care Evaluation Studies are being conducted which include Title XIX recipients. However, our interviews revealed that the Title XIX single State agency has not made these studies a requirement. Thus, the studies are only being conducted because of other requirements of JCAH accreditation and Title XVIII.

Stockton State Hospital staff indicated that they were not aware of such a requirement for MCE studies by DHS, and therefore are not conducting such studies on Title XIX recipients.

Recommendation:

DHS should notify all Title XIX providers that MCE studies are a requirement and a condition of participation (42 CFR 450.19(x)).

2. Finding - Written Criteria unavailable

In the Field Offices and facilities, consistent written criteria for the medical necessity for admissions and continued stay are not being used. Medi-Cal consultants are primarily using professional judgment in making these decisions. One State Hospital visited, had its own "internal criteria" (Attachment I). In response to a letter regarding the submission of additional documentation supporting the request for a waiver for the Mental Hospitals, which was addressed to M. Keith Weikel (dated 10/21/77), DHS in describing its system stated:

> *The Medi-Cal physician consultant reviews the TAR and compares it with the file of previously approved or denied TARS for the beneficiary. From the information the Medi-Cal consultant decides on the basis of his/her medical judgment and standards of practice in the community to approve, deny, modify, or return the TAR for additional information...*

Based on discussions with Field Office and facility staffs, it appears that continued stay criteria used to determine length of stay for private facilities and state institutions is not consistent.

Recommendation:

Written criteria (42 CFR 450.18(5)(c)) must be utilized by Medi-Cal consultants during the period in which the State's present utilization review system continues to be in effect. Moreover, such criteria should be uniformly applied to all facilities classified as Institutions for Mental Diseases - private or State operated.

Program Subsystems

At the present time, the State's system of utilization control includes three special projects and State operated facilities which all deviate somewhat from the State's waivered system. The three special projects are:

1. CDS - California Dental Society
2. Redwood Project
3. Fresno/Madera Project

CDS is an "at risk" contract with its own prior authorization system for dental services. Risk means that the contractor (CDS) agrees to provide covered care for all enrolled recipients at a given capitation rate, regardless of whether the cost is greater or less than the capitation rate.

The Redwood Project covers public assistance and medical assistance recipients and includes all program services except dental. It is also an "at risk" contract with its own prior authorization system. Geographically, the contract area includes three California counties; i.e., Sonoma, Lake, and Mendocino.

The Fresno/Madera Project was implemented on November 1, 1972. The contract for the project was accomplished by an amendment approved by the Department of Health Services to an existing contract between the Foundation for Medical Care of Fresno County and the Department's fiscal intermediary, Medi-Cal Intermediary Operations (MIO). All providers of services in Fresno and Madera counties are included in the Fresno/Madera pilot project for utilization review. Prior authorization has been eliminated and all billing forms are forwarded to the fiscal intermediary for payment. With the exception of the peer review activity, providers in this project area basically follow the Title XVIII UR system.

Findings and Recommendations - Program Subsystems

Finding - DHEW Approval

There is no record which indicates the Fresno/Madera project or a description of the UR system in operation under the Redwood Project was ever submitted to DHEW for approval.

Recommendations:

1. DHS should submit to DHEW the Fresno/Madera Project and a description of the UR system under the Redwood project for approval.

2. Since some of the special projects have been in operation for approximately five years, the State should make a decision as to which system is the superior one. To accomplish this, the State could make use of the various evaluations done on the sub-systems and determine which one is most cost effective and superior to other systems. The two most recent evaluations of the Fresno/Madera Project were: (1) An Evaluation of the Cost Effectiveness of Peer Review in Fresno and Madera Counties, a report of the State of California Department of Health, report number 501-6043-601, July 9, 1976; and (2) The Fresno/Madera Pilot Project: An Evaluation of the Cost Effectiveness of Peer Review, Socioeconomic Report, Division of Research and Socioeconomics, Bureau of Research and Planning - California Medical Association, San Francisco, California, Vol. XVII, No. 6, October - November, 1977.

State Operated Facilities

The State mental hospitals operate under the prior authorization TAR system, with one deviation; i.e., the payment for services rendered is an intra-State payment system. Thus, the TARS generated by the hospitals are not sent to MIO for payment but retained by the hospital and Field Office The hospital then transmits a list of recipients by level of care to the Benefits Payments Section of the Department of Health Services, where the amount charged for care at the given level for the recipient, or group of recipients, is deducted internally from the State's Medi-Cal Budget.

Admissions to State facilities can occur through:

1. Referrals from Regional Centers
2. Court commitment
3. Emergency
4. Transfers from private institutions

Findings and Recommendations - State Operated Facilities

1. Finding - Level of Care

State Central Office staff and State mental hospital staff indicated that there existed an ICF/DD (Developmentally Disabled) level of care which is synonymous to the federal ICF/MR level of care, however, we found no evidence to document certification for such a level.

Recommendation:

DHS should make every effort to ensure that all State operated mental hospitals are properly certified for the levels of care for which recipients are receiving services. This is especially critical in the ICF/DD (ICF/MR) area. The levels of care for which State institutions are certified have major implications for staffing, proper care and space requirements for ICF/DD (ICF/MR) recipients. Attachment #2 represents the situation that exists at Stockton State Hospital in regards to ICF/DD. The Single State Agency must also ensure that there is a qualified mental retardation professional on the IPR team for the ICF/DD Medi-Cal recipients' annual review. References: 42 CFR 442.411 - 442.431 - staffing; 42 CFR 442.447 - Space requirements; 42 CFR 42 CFR 456.602 - Inspection teams.

2. Finding - Medi-Cal Funded Positions in State Hospitals

According to State personnel, Medi-Cal funds 45 positions in nine State institutions which primarily house the developmentally disabled. Each facility currently has one Medi-Cal Consultant II and four Medi-Cal Consultants I. A review of the proposed 1977-78 Governor's budget, which we were told was subsequently approved, shows that there are 129.5 hospital based treatment positions in State Hospitals funded in total by the Medi-Cal program. The following illustrates the positions by professional discipline:

Developmentally Disabled (9 facilities)

Staff Psychiatrist	.2
Physicians and Surgeons	2.6
Medi-Cal Nursing Coordinator II	9
Teacher	4
Medi-Cal Nursing Coordinator I	35
Psychiatric Social Worker	7.5
Social Work Associate	38.6
Clerical	21.5

Mentally Disabled (5 facilities)

Physicians and Surgeons	3.1
Social Work Associate	4
Clerical	4

During the review process, one Medi-Cal Nurse Consultant II was interviewed. The individual reported that personnel in these positions report to the administrators of the individual institutions, not to the Medi-Cal Field Offices. The role of these individuals, as far as Medi-Cal functions are concerned, was never clearly defined to review team members. The team was informed, however, that individuals in these positions had worked in supervisory capacities for the hospitals. Admission review, continued stay review (TAR system) and annual medical reviews are being conducted by the staff of the Medi-Cal field offices. No responsibilities of Medi-Cal Field Office staff are being eliminated as a result of having Medi-Cal funded Nursing Coordinators on-site in these institutions.

Recommendation:

Personnel in Medi-Cal funded positions in State institutions must perform Medi-Cal related functions. They should report to other senior level State staff e.g. Medi-Cal Field Office administrators, rather than the hospital administrator of the facility in which they work. The State must ensure that personnel in these positions do not duplicate activities performed by Medi-Cal Field Office staff. If these positions are not being used to reduce or eliminate the work required of Medi-Cal Field Office staff, they should not be funded by Medi-Cal.

Medical Review/Independent Professional Review

Title XIX recipients in long-term-care (LTC) facilities are reviewed annually by the Field Office medical review teams (42 CFR 450.23 and 450.24). Level of care (LOC) criteria are contained in the California Administrative Code, Title 22. A three-part document, Form MC-3003 is used by medical review team members to record information obtained during the nursing, medical, and social assessment of each recipient. The RN team member personally contacts each recipient and refers any level-of-care (LOC) changes to the social service consultant for review. The Medi-Cal physician consultant reviews a minimum of 8% of the recipients, including any LOC determinations questioned by the RN.

Findings and Recommendations -MR/IPR

1. Finding - Social Service Component of Medical Review

The social service component of the medical review (MR) process is weak. In accordance with State guidelines, the social service consultant reviews a minimum of 13% of the residents in a LTC facility during the annual medical review. Often times, the social worker is not present during the on-site visit conducted by the RN team member. Futhermore, evidence of integration of the social and nursing assessments is lacking. MR team members and facility representatives stated that the MR team does not always conduct the review as a "team". Field Office staff related that this was primarily due to an inadequate number of social workers to handle the workload. Scheduling visits whereby the RN and social worker can be on-site simultaneously is difficult when two offices must share a social worker.

Recommendation:

The State needs to ensure that the social needs of LTC residents are being met. Each Field Office should be adequately staffed so that a social services consultant can be part of the team during the on-site medical review process. The nursing and social assessments should be integrated to meet the intent of the regulations regarding an annual medical review by an interdisciplinary team.

2. Finding - Follow-up on Medical Review Findings

Medical review team members were unsure as to follow-up activities on facility reports resulting from the annual review. All facility reports are forwarded to Licensing and Certification. If immediate action is required, the MR team phones Licensing and Certification consultants from the facility. However, MR teams are not always notified of actions taken by Licensing and Certification in response to the identified problem. Thus, if the MR teams cannot personally follow-up on a particular problem area, they may not be made aware whether corrective actions have begun.

Recommendation:

The State should improve communications between Licensing and Certification and the Field Office MR teams. If follow-up is the responsibility of Licensing and Certification, the MR teams should be kept informed of actions taken to correct problem areas.

Prior Authorization

According to the California Administrative Code, Title 22, prior authorization means authorization granted by a designated Medi-Cal consultant in advance of the rendering of a service, unless otherwise specifically stated, after appropriate medical review. Prior authorization is required for all items listed in Attachment 3. Copies of Treatment Authorization Request (TAR) forms are contained in Attachment 4.

Retroactive approval of requests for prior authorization may be granted only under the following conditions:

1. When certification of the Medi-Cal beneficiary's eligibility by the county welfare department is delayed;

2. When "other coverage" (e.g., Medicare or other health insurance programs) denied payment of a claim for services;

3. When communication with the Medi-Cal consultant could not be established and provision of the required service should not have been delayed; under this condition the request for retroactive authorization must be received by the Medi-Cal consultant within 10 calendar days after the service is provided or initiated;

4. When a patient does not identify himself to the provider as a Medi-Cal beneficiary by deliberate concealment or because of physical or mental incapacity to so identify himself. The request for retroactive authorization must be accompanied by a statement from the provider certifying that the patient did not identify himself and the date the patient was so identified, provided such date is within one year after the month in which service was rendered. The request for retroactive authorization must be submitted within 60 days following the certified date of beneficiary identification.

Reauthorization means authorization of a request received by the Medi-Cal consultant before the expiration of the previous authorization for a service being rendered.

All authorization requests must include adequate information and justification for the service requested for the beneficiary.

Authorization may be granted only for items or services that are medically necessary and do not exceed the items or services received by the public generally for similar medical conditions. Such authorization is valid for the number of days specified by the Consultant up to a maximum of 120 days, unless otherwise specified. Authorization may be granted only for the lowest cost items or service covered by the program that meet the patient's medical needs. A provider may appeal the decision of a Medi-Cal consultant on a treatment authorization request (TAR). Such an appeal must be initiated within 30 days from the date of provider notification of the Medi-Cal consultant's decision. The following must be met:

1. The appeal must be submitted in writing to the Medi-Cal consultant;

2. If the Medi-Cal consultant finds no basis for altering his original decision, he will forward the appeal along with his recommendation and basis thereof, to the Field Services District Office. If the appeal cannot be satisfactorily resolved at this level, the District Office will forward the appeal to the Department Headquarters. The provider will be informed of each referral;

3. The Department must act on the appeal and inform the provider directly within 60 calendar days from receipt of the appeal by the Medi-Cal consultant.

Findings and Recommendations - Prior Authorizations

Finding - Review of Title XIX Claims by Fiscal Intermediary

Claims that have been approved for payment under the State's TAR system are being re-reviewed by the fiscal intermediary, MIO. In Southern California, Blue Cross (a part of MIO) employs thirteen registered nurses and twenty MD consultants who, in addition to other review activities, conduct a post-service, pre-payment review of all Title XIX claims over the 75th percentile. These claims have already been approved for payment under the State's TAR system. Blue Cross reviewers have no authority to adjust or deny payment. (The fiscal intermediaries do have the authority to review and adjust payment for emergency admissions of 3 days duration or less, as well as all ancillary services.) A record is maintained comparing decisions made by Medi-Cal consultants and the PSRO with those made by Blue Cross reviewers. These reports are forwarded to the State Agency for educational purposes. However, the State reportedly makes minimal use of the data.

Recommendation:

In order to eliminate duplication, the State should direct the fiscal intermediary to discontinue the process of reviewing the Medi-Cal and PSRO approved claims for medical necessity and length of stay. The State should negotiate a written change in the present fiscal intermediary contract, and eliminate such review requirements in the new fiscal intermediary contract, if applicable.

Professional Standards Review Organizations

The State of California has 28 designated PSRO areas. There are currently 23 conditional PSROs and 5 in planning status (Attachment 5). Routine relations between the PSROs and Medi-Cal are conducted by the Executive Directors of the PSROs and the PSRO unit of the Medi-Cal Field Services Section.

All of the conditional PSROs have implemented Title XVIII acute review. Only nine have implemented Title XIX acute review. The Medi-Cal agency has shown great reluctance to sign Memoranda of Understanding (MOUs) with PSROs permitting them to implement Title XIX acute review (See Attachment 6 for a chronology of critical dates in California - Federal PSRO relations). Negotiations are currently at a stalemate due to disagreements over the State's monitoring plan.

Only two PSROs have implemented Title XVIII long-term-care review (Greater Sacramento Area PSRO and San Joaquin PSRO). Medi-Cal is currently negotiating with three PSROs (the two previously named and Redwood Coast Region PSRO) to conduct special SNF review projects. The State will possibly sign MOUs with these and other PSROs at the conclusion of the projects.

The Medi-Cal Agency is presently monitoring the results of the PSROs which conduct Medi-Cal review. The State is using the monitoring plan which is still being negotiated. The results should be available in January, 1979. The State has participated in all Central Office and Regional Office Health Standards and Quality Bureau (HSQB) assessments of California PSROs. They have reviewed and commented on all PSRO applications for conditional and operational designation and all plans for conducting long-term-care review.

Findings and Recommendations - PSRO

Finding - PSRO Review Implementation

Only nine of 23 conditional PSROs have been able to successfully negotiate MOUs with the State and implement Title XIX review as required by Section 1155(a)(1) of the Social Security Act.

Recommendation:

The State should quickly negotiate MOUs with the remaining 14 conditional PSROs and the other five PSROs when they attain conditional status.

ATTACHMENTS

10-24-78

Stockton State Hospital

STATE HOSPITAL CRITERIA
ATTACHMENT 1

FORM 1282-WORKSHEET - MEDI-CAL NURSING CARE CRITERIA

IDENT'S NAME ________________ DATE ________ UNIT ________

DENT IS QUALIFIED FOR: Skilled Nursing Care ____ CHANGED FROM ________ STATUS
Intermediate Care (DD) ____ CIRCLE ONE: Annual - Semi-Annual
Residential Care ________ DATE OF ADJUDICATION ________

RMINATION MADE: For Trust Office ____; By I.D. Team ____; or, other ________

Signature of Medi-Cal Staff Member ________________

****

SELF-INJURIOUS: a) Ingests foreign objects; b) Bangs own head and/or limbs; c) Mutilates own body; d) Other ________

INCONTINENT: a) Enuresis (a.m.); b) Enuresis (NOC); c) Feces (a.m.); d) Feces (NOC); e) Toilet Training Program (a.m.); f) Toilet Training Program (NOC); g) Other ________

COMBATIVE: a) Hits; b) Kicks; c) Bites residents and/or staff; d) Other ________

SEXUAL BEHAVIOR: a) Aggressive; b) Inappropriate; c) Disrobes publicly; d) Other ________

HEAVY DRUG DOSAGE: i.e., dosage would alarm an outside physician; ________

SEIZURES: a) If uncontrolled, or extremely severe (seizures that would require prompt medical attention; b) Or, prolonged nursing care following seizure; c) Other ________

OBVIOUS PSYCHOSIS: Hallucinates; b) Delusional; c) Other ________

HYPERACTIVITY: a) Paces; b) Excess abundance of energy which would be an annoyance to others; c) Other ________

AGGRESSIVE: (Any offensive action against the rights of others): a) Takes other's property in a meaningless manner (confused, etc. - see C.M.R. definition); b) Threatening; c) Grabs food; d) Other ________

OFFENSIVE ACTIONS/HABITS: a) Regurgitates; b) Smears feces; c) Other ________

DISRUPTIVE: a) Teases others; b) Ritualistic mannerisms that annoy peers & staff; c) Noisy; d) Echolalia; e) Other ________

TEMPER TANTRUMS: a) Screams; b) Throws property; c) Other ________

RETURNS FROM PLACEMENT: a) Because of problems relating to resident's behavior; or, b) Other ________

DESTRUCTIVE: Destroys -- a) Clothing; b) Property; c) Other ________

STEALING: Must be a premeditated, calculated, planned act; or Other, ________

HOARDS: a) Food; b) Items; c) Other ________

SEVERE DEFORMITY: a) Spasticity; b) Hemiplegic; c) Paraplegic; d) Blind; e) Deaf Mute; f) Non-ambulatory; g) Other ________

SEVERE MEDICAL PROBLEMS: i.e., a) Diabetes; b) Cardiac; c) Other ________

PROFANITY: a) Verbal obscenities; b) Cursing; c) Other ________

DANGER TO SELF OR OTHERS: i. e., a) Suicidal; b) Threatening, or doing serious bodily harm to others; c) Other ________

DANGEROUS SMOKER: To qualify as dangerous smoker, one would have to be a danger to, a) Himself; b) To others; c) To property; d) Other ________

CHOKES ON: a) Food; b) Other ________

INTERMEDIATE CARE (D.D.): See new regulations ________

ATTACHMENT #2

State of California **Health and Welfare Agency**

Memorandum

To : Santi Rogers
Executive Director

Date : September 26, 1978

File No.:

Nita P. Calestini, M.S.W.
Clinical Director

From : **Stockton State Hospital**
510 E. Magnolia St., Stockton, CA 95202

Subject: QUALIFIED MENTAL RETARDATION PROFESSIONAL AT STOCKTON STATE HOSPITAL

I. Problem:

This facility is not currently in complete compliance with federal licensing requirements for facilities for the mentally retarded relative to the assignment of Qualified Mental Retardation Professionals to all developmentally disabled clients.

II. Discussion:

Although Stockton has, in the past, appointed individuals who met the requirements as defined in HEW regulations as Qualified Mental Retardation Professionals, those individuals are Program Directors or program managers who cannot meet the intent of the HEW regulations due to the numbers of clients involved.

III. Findings:

Program Managers can/not possibly meet the intent of the regulations insofar as its importance to know the facts regarding each client's problems, each client's current status, and each client's plans for the future. Relative to meeting intent of the regulations, it appears that we could meet intent with the assignment of psychiatric technicians as QMRPs, however, psychiatric technicians are not designated as acceptable under current HEW regulations.

IV. Recommendations:

I recommend that each client treated in the facility be assigned one nursing service staff member and one professional(*) staff member who jointly would be responsible for the development of the client's monthly update plan.

V. Implementation:

Implementation would become effective October 2, 1978.

Thirty days following the admission of any newly accepted client in the facility, the Program Director, during the 30- day assessment, will assign one professional staff member and one nursing services staff member as the QMRPs responsible for the over all knowledge and planning for the client.

For clients who are already in each Program, the Program Director will assign,or cause to be assigned, one nursing services staff member and one professional staff member as Qualified Mental Retardation Professionals.

The QMRPs will jointly develop the monthly assessment and jointly sign the assessment for the clinical record.

Professional staff members and nursing staff members may be QMRPs for more than one client.

A task force, to be assigned by the Clinical Director, will develop a monthly update format to assist the two QMRPs. The task force will be appointed by October 3, 1978. The draft will be prepared by October 10, 1978.

NPC:lc

* Professional means those individuals designated in HEW regulations

PRIOR AUTHORIZATION
ATTACHMENT #3
10/78

MEDI-CAL UTILIZATION REVIEW

Prior Authorization is Required for the Following Items:

1. All hospitalizations other than emergencies;
2. Emergency admissions followed by hospitalization beyond the third day;
3. Skilled nursing facility or intermediate care facility placement;
4. All purchase, cumulative rental, or repair of durable medical equipment in excess of $25;
5. The third and subsequent tanks of oxygen in a calendar month;
6. All purchase, rental or repair of prosthetics and orthotics over $25;
7. Medical transportation, other than in an emergency;
8. Physical therapy services in excess of two a month;
9. Drugs not listed in the drug formulary - unless these are used in the course of an acute hospitalization or prescribed as discharge medications to a patient leaving hospitalization;
10. Podiatry services in excess of two a month unless rendered on an emergency basis;
11. Purchase of hearing aids and repairs in excess of $10;
12. Home Health Agency Services other than one evaluative visit in a six-month period;
13. Psychiatric treatment in excess of eight visits in 120 days;
14. Allergy services only if involved with Desensitization;
15. Dental services (by contract to California Dental Service).

Requires Medi-Label (Confined to two visits per month maximum)

1. Chiropractic services.
2. Psychological services.
3. Speech therapy - (unless provided as inpatient service or outpatient service of Rehabilitation Center with prior authorization for more than one visit in six months).

4. Occupational therapy - (unless provided as inpatient service or outpatient service of Rehabilitation Center with prior authorization for more than one visit in six months).

5. Audiological services - unless provided as inpatient service or outpatient service of Rehabilitation Center.

6. Optometry services

Requires Proof-of-Eligibility (POE) label. (Not subject to prior authorization)

1. Outpatient physician visits.

2. Eye glasses, prosthetic eyes, and other eye appliances.

3. Psychiatric services (eight outpatient visits in 120 days or less).

10/78
WH:gg

PRIOR AUTHORIZATION
Attachment #4

SEE INSTRUCTIONS ON REVERSE SIDE
PLEASE TYPE OR PRESS FIRMLY WITH FINE BALL POINT - MAKE SURE 4TH COPY IS LEGIBLE

Uarco Business Forms Ro

DEPARTMENT OF HEALTH

MEDI - CAL
TREATMENT AUTHORIZATION AND PAYMENT REQUEST

STATE OF CALIFORNIA

470443

☐ TRANSFER
☐ INITIAL

☐ REAUTHORIZATION
☐ CO-INSURANCE

☐ SKILLED NURSING CARE
06

☐ INTERMEDIATE CARE
09

PLACE
LABEL
HERE

PART I TO BE COMPLETED BY PROVIDER

1 NAME OF PATIENT (LAST)	(FIRST)	(M I)	2 IDENTIFICATION NUMBER CO AID CASE NO FBU PERSON	3 SEX	4 BIRTHDATE MO YR
5 ADM DATE OF THIS SERVICE	6 MEDI-CARE STATUS	7 DATE MEDI-CARE BENEFITS EXHAUSTED	8 SOCIAL SECURITY CLAIM NO	9 MEDICAL RECORD NO	10 TELEPHONE CONTROL NUMBER

NAME AND ADDRESS OF PROVIDER OF SERVICE

PROVIDER NO

This is to certify that the BILLING information is true accurate and complete I understand that payment and satisfaction of this claim will be from Federal and State funds and that any false claims statements or documents or concealment of a material fact, may be prosecuted under applicable federal or State laws **NOTE:** Treatment authorization does not guarantee payment Payment is subject to patient's eligibility Be sure patient has identification Card

X ______ DATE ______
SIGNATURE AND TITLE OF NURSING HOME REPRESENTATIVE

BILLING DATA - To be completed at time of billing

DATES OF SERVICE						S CODE	ICD CODE	DISCHG. REAS.	SP CODE	TOTAL DAYS	DAILY RATE	GROSS AMOUNT	PATIENT LIABILITY	OTHER COVERAGE	NET AMOUNT BILLED
FROM			TO												
MO	DAY	YR	MO.	DAY	YR.										
MO	DAY	YR.	MO.	DAY	YR										

PART II TO BE COMPLETED BY ATTENDING PHYSICIAN PERIOD OF CARE REQUESTED 12 FROM (DATE)______ TO (DATE)______

13 A CURRENT DIAGNOSES (PRIMARY)______

(SECONDARY)______

B ADMITTED FROM ACUTE HOSPITAL CARE ☐ HOSPITAL SKILLED NURSING CARE ☐ SKILLED NURSING FACILITY ☐ INTERMEDIATE CARE ☐ BOARD AND CARE HOME ☐ HOME ☐

Name Former Facility:______

C DAILY MEDICATIONS (NAME-DOSAGE-FREQUENCY) 1.______ 2.______
3.______ 4.______ 5.______

D PATIENTS GENERAL CONDITIONS, LIMITATIONS AND NURSING PROCEDURES REQUIRED

☐ BEDRIDDEN SPECIFY______
☐ TOTALLY INCONTINENT
☐ SPOON FED
☐ CONFINED TO WHEEL CHAIR
☐ AMBULATORY WITH ASSISTANCE
☐ AMBULATORY

E DIET______ F. ATTENDING PHYSICIAN'S LAST VISIT: (DATE)______

14 THIS IS TO CERTIFY THAT THE ABOVE INFORMATION IS TRUE, ACCURATE AND COMPLETE AND THAT THE PATIENT REQUIRES OUT-OF-HOME CARE

DATE ______ SIGNATURE OF PHYSICIAN X ______

15 NAME OF PHYSICIAN (TYPE OR PRINT)	16 LICENSE NO	17 ADDRESS	18. PHONE NO

PART III FOR MEDI-CAL CONSULTANT

19 Retroactive authorization, if applicable, has been granted in accordance with Section 51003 (b) (1) ☐ OR (2) ☐ OR (3) ☐ OR (4) ☐

20 SKILLED NURSING CARE ☐ APPROVED FROM (DATE) TO (DATE)	21 INTERMEDIATE CARE ☐ APPROVED FROM (DATE) TO (DATE)
22 ☐ CARE DISAPPROVED - REASON AND ALTERNATE TREATMENT PLAN RECOMMENDED	23 SIGNATURE OF MEDI-CAL CONSULTANT X

24 F I USE ONLY	25	26	30
27	28	29	

NO. 1 - MEDICAL CONSULTANT COPY

MC 170 (REV 10-73)

(U) H63042

INSTRUCTIONS 81.

Medical Equipment

DOCTOR.— USE TYPEWRITER OR BALL POINT PEN. AFTER EXAMINATION MAIL WHITE, YELLOW AND BLUE FORMS WITH CARBONS BETWEEN TO MEDI-CAL CONSULTANT NAMED ON PATIENT'S IDENTIFICATION CARD. RETAIN PINK COPY FOR YOUR FILES.

Electr Adm 611868 5B

STATE OF CALIFORNIA

DEPARTMENT OF HEALTH

MEDICAL
TREATMENT AUTHORIZATION REQUEST

FOR PROVIDER'S USE

NAME AND ADDRESS OF PATIENT	AGE	SEX	PATIENT'S IDENTIFICATION CO	AID	CASE NO.	FBU	PERS. NO.

NAME OF COUNTY

PLEASE PRINT YOUR NAME AND ADDRESS HERE

THE ABOVE NAMED PATIENT IS IN NEED OF ADDITIONAL TREATMENT WHICH WILL EXCEED THE AMOUNT AUTHORIZED WITHOUT PRIOR APPROVAL. INITIAL DIAGNOSTIC IMPRESSIONS:

AUTHORIZATION IS REQUESTED TO CLAIM PAYMENT FOR THE FOLLOWING RECOMMENDED TREATMENT:

DESCRIPTION (BE SPECIFIC)	PROCEDURE NO.	CHARGES

SIGNATURE DEGREE DATE

NOTE: AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PAYMENT IS SUBJECT TO PATIENT'S ELIGIBILITY. BE SURE THE IDENTIFICATION CARD IS CURRENT BEFORE RENDERING SERVICE.

FOR STATE USE

PROVIDER:

☐ YOU ARE AUTHORIZED TO CLAIM PAYMENT FOR TREATMENT AS RECOMMENDED BY YOU. AUTHORIZATION EXPIRES IN ____ DAYS

☐ REQUEST DENIED.

COMMENTS:

☐ YOU ARE AUTHORIZED TO CLAIM PAYMENT FOR TREATMENT CHECKED "YES".

AUTHORIZATION EXPIRES IN ____ DAYS.

AUTHORIZED YES	NO	EXPLANATION

MEDI-CAL CONSULTANT

BY ____

DATE ____

MC - 161 (REV. 1-74)

5C

STATE OF CALIFORNIA
HEALTH AND WELFARE
AGENCY

DEPARTMENT
OF HEALTH

CONFIDENTIAL PATIENT INFORMATION
MEDI-CAL

REQUEST FOR STAY IN HOSPITAL

Please review instructions on reverse side.

FOR HOSPITAL

1 Name of Patient (Last) (First) (M.I.)

5 ADMISSION DATE MO. DAY YR

6 EMERGENCY ADMISSION YES ☐ NO ☐

2 MEDI-CAL IDENTIFICATION NO. Co. Aid Case F.B.U Pers

SEX M. ☐ F. ☐

DATE OF BIRTH MO. YR.

AGE

SOCIAL SECURITY NO.

7 CURRENT AUTHORIZATION EXPIRES MO DAY YR.

8 PHONE CONTROL NO.

3 OTHER COVERAGE

MEDICARE YES ☐ NO ☐

CHAMPUS YES ☐ NO ☐

4 Name of Hospital

Street

City State Zip

9 ADMITTING DIAGNOSIS

10 NO. OF DAYS REQUESTED ☐ ACUTE ______ DAYS ☐ ______ DAYS

FOR PHYSICIAN—Please provide sufficient essential detail to permit a reasonable evaluation of the length and level of care requested.

11 What is the present diagnosis?

12 Describe current condition requiring extension. Include pertinent lab and x-ray reports with dates.

13 What planned procedures will require this extension. Include dates when possible.

14 Type or print name of responsible physician

Signature of responsible physician X

DATE

FOR MEDI-CAL CONSULTANT—Validating information and explanation.

15

16 ___ days of Hospital Acute Care Approved From ______________ thru ______________

___ days of Hospital Extended Care Approved From ______________ thru ______________

17 ___ days of this hospitalization are denied (Explain in No. 15 above) Dates:

18 Signature of Medi-Cal Consultant

NOTE: Approval of this request is not a guarantee of payment. Payment is subject to patient's current eligibility and to medical utilization review. Be sure patient has current identification card.

MC-180 (8-78)

Hospital Billing Copy

5D

SEE INSTRUCTIONS ON REVERSE SIDE

PLEASE TYPE OR PRESS FIRMLY WITH FINE BALL POINT - MAKE SURE 4TH COPY IS LEGIBLE

DEPARTMENT OF HEALTH

MEDI-CAL TREATMENT AUTHORIZATION AND PAYMENT REQUEST

STATE OF CALIFORNIA

PLACE LABEL HERE

☐ TRANSFER
☐ INITIAL
☐ REAUTHORIZATION
☐ CO INSURANCE

☐ SKILLED NURSING CARE 06
☐ SPECIAL PROGRAM
☐ 16 REHABILITATION 19 ☐
☐ 26 SUBACUTE PSYCHIATRIC 29 ☐
☐ 36 DEVELOPMENTAL DISABILITY 39 ☐
☐ 46 DEVELOPMENTAL DISABILITY ON LEAVE 49 ☐

☐ INTERMEDIATE CARE 09

CONFIDENTIAL PATIENT INFORMATION

A 158079

PART I TO BE COMPLETED BY PROVIDER

1. NAME OF PATIENT (LAST) (FIRST) (M.I.)
2. IDENTIFICATION NUMBER CO. AID CASE NO. FBU PERSON
3. SEX
4. BIRTHDATE MO. DA. YR.
5. ADM DATE OF THIS SERVICE
6. MEDI-CARE STATUS
7. DATE MEDI-CARE BENEFITS EXHAUSTED
8. SOCIAL SECURITY CLAIM NO.
9. MEDICAL RECORD NO.
10. TELEPHONE CONTROL NUMBER

11. NAME AND ADDRESS OF PROVIDER OF SERVICE PROVIDER NO.

05507F
VC 80

CARMICHAEL CONV HOSP
8336 FAIR OAKS BLVD
CARMICHAEL CA 95608

This is to certify that the BILLING information is true and accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds. In addition I certify that I will seek payment from the patient for the amount shown on the Medi-Cal ID card as the patient's share of cost (liability), and I will neither claim nor accept payment from the Medi-Cal program for that amount. I understand that any false claims, statements or documents, or concealment of a material fact, may be prosecuted under applicable State laws.

NOTE: Treatment authorization does not guarantee payment. Payment is also subject to the following:

1 Patient eligibility. (Be sure patient has a current identification card.)
2 Provider of service must be certified by the Department of Health to participate in the Medi-Cal Program and must have a current Provider Participation Agreement and or provider number for the appropriate level of care.
3 Further utilization review by the Fiscal Intermediary and or The Department of Health.

X DATE

SIGNATURE AND TITLE OF NURSING HOME REPRESENTATIVE

12. BILLING DATA - To be completed at time of billing

DATES OF SERVICE FROM MO	DAY	YR	TO MO	DAY	YR	ROOM NO.	ICD CODE	DISCHG. REAS.	SP CODE	TOTAL DAYS	DAILY RATE	GROSS AMOUNT	PATIENT SHARE OF COST	OTHER COVERAGE	NET AMOUNT BILLED

PART II TO BE COMPLETED BY ATTENDING PHYSICIAN:

13. PERIOD OF CARE REQUESTED FROM (DATE) ______ TO (DATE) ______

14. A. CURRENT DIAGNOSIS (PRIMARY) ______

B. ADMITTED FROM: (SECONDARY) ______

ACUTE HOSPITAL CARE ☐ HOSPITAL SKILLED NURSING CARE ☐ SKILLED NURSING FACILITY ☐ INTERMEDIATE CARE ☐ BOARD AND CARE HOME ☐ HOME ☐

NAME FORMER FACILITY: ______

C. DAILY MEDICATIONS: (NAME-DOSAGE-FREQUENCY) 1. ______ 2. ______

3. ______ 4. ______ 5. ______

D. PATIENT'S GENERAL CONDITION, LIMITATIONS AND NURSING PROCEDURES REQUIRED:

☐ BEDRIDDEN
☐ TOTALLY INCONTINENT
☐ SPOON FED
☐ CONFINED TO WHEEL CHAIR
☐ AMBULATORY WITH ASSISTANCE
☐ AMBULATORY

SPECIFY ______

E. DIET: ______ F. ATTENDING PHYSICIAN'S LAST VISIT: (DATE) ______

15. THIS IS TO CERTIFY THAT THE ABOVE INFORMATION IS TRUE, ACCURATE AND COMPLETE AND THAT THE PATIENT REQUIRES OUT-OF-HOME CARE.

DATE ______ SIGNATURE OF PHYSICIAN X ______

16. NAME OF PHYSICIAN (TYPE OR PRINT) 17. LICENSE NO. 18. ADDRESS 19. PHONE NO.

PART III TO BE COMPLETED BY MEDI-CAL CONSULTANT

20. RETROACTIVE AUTHORIZATION, IF APPLICABLE HAS BEEN GRANTED IN ACCORDANCE WITH SECTION 51003(B) (1) (2) (3) (4) (CIRCLE ONE)

21. ☐ ADMINISTRATIVE DAYS (BED NOT AVAILABLE)
☐ AID PAID PENDING (REQUEST FOR FAIR HEARING)

22. SKILLED NURSING CARE ☐ APPROVED FROM (DATE) TO (DATE) PROLONGED CARE ☐ YES ☐ NO

23. INTERMEDIATE CARE ☐ APPROVED FROM (DATE) TO (DATE) PROLONGED CARE ☐ YES ☐ NO

24. ☐ CARE DISAPPROVED - REASON AND ALTERNATE TREATMENT PLAN RECOMMENDED

25. SIGNATURE OF MEDI-CAL CONSULTANT

X

26. FI USE ONLY	27.	28.	32.
29.	30.	31.	

MC 170 (REV. 8/77) **NO. 1 MEDICAL CONSULTANT COPY**

egion IX PSROs
~~age 2~~

	alifornia	Status*	PSRO Contact	HEW Contact**
	California Statewide PSR Council One California, Suite 2810 San Francisco, CA 94105 415/435-4369; 434-4373		Hugh McWilliams Exec. Secretary 240-77-0081	Lois Seidler 415/556-9114
I	Redwood Coast Region PSRO 3416 Mendocino Avenue Santa Rosa, CA 95401 707/528-8585 (Dial 9)	C	Anne Martin Exec. Director HSA-105-74-41	Karen Fuller 415/556-9116
II	Superior California PSRO 813 East Fifth Avenue Chico, CA 95926 916/895-3266	C	Robert Britton Exec. Director 240-77-0025	Ken Hughes 415/556-9115
III	North Bay PSRO 4460 Redwood Highway Suite 9 San Rafael, CA 94903 415/472-7771 (Dial 9)	C	Janet Connaughton Exec. Director HSA-105-74-45	Steve Suard 415/556-9100
IV	Greater Sacramento Area PSRO P.O. Box 13978 Sacramento, CA 95813 916/929-8854 (8-448-2000 FTS)	C	Reg Claytor Exec. Director 240-75-44	Fred Zentgraf 415/556-9112
V	San Francisco PRO 1375 Sutter Street, Suite 402 San Francisco, CA 94109 415/775-3262 (Dial 9)	C	Todd Anderson Exec. Director HSA-105-74-85	Vona Poole 415/556-9132
VI	Mid-Peninsula PSRO 1710 South Amphlett, Suite 225 San Mateo, CA 94402 415/574-8687 (Dial 9)	C	David Knetzer Exec. Director Howard W. Lindsey M.D. HCFA-500-77-0014	Ken Hughes 415/556-9115

rea		Status*	PSRO Contact	HEW Contact**
VII	Alameda-Contra Costa PSRO Suite 2F 1717 North California Blvd. Walnut Creek, CA 94596 415/937-9800	P	Maurice Sandler, M.D. Board President HCFA-500-78-0024	Steve Suard 415/556-9100
III	San Joaquin Area PSRO 555 West Benjamin Holt, #421 Post Office Box 1972 Stockton, CA 95201 209/951-6711 (Dial 9)	C	Dan Sheehy Exec. Director HSA-105-74-179	Steve Suard 415/556-9100
IX	Santa Clara Valley PSRO 700 Empey Way San Jose, CA 95128 408/294-2120 (Dial 9)	C	Harlan Bennett Exec. Director HSA-105-74-47	Fred Zentgraf 415/556-9112
X	Stanislaus-Merced-Mariposa PSRO 2030 Coffee Road, Suite A-6 Post Office Box 1755 Modesto, CA 95354 209/526-8450 Ext. 24 (Dial 9)	C	Nilda Johnson Project Director Barbara Cotton HSA-105-74-122	Steve Suard 415/556-9100
XI	Fresno-Madera PSRO, Inc. 3425 North First Street, Rm. E-19 Fresno, CA 93726 209/229-6545; FTS 8-467-5000	C	Naomi Kumagai Project Director	Fred Zentgraf 415/556-9112
XII	Monterey Bay Area PSRO Post Office Box 308 Salinas, CA 93901 0-408/455-1833 (Dial 0)	C	Edgar Colvin Exec. Director HSA-105-74-31	Fred Zentgraf 415/556-9112
III	The PSRO for Tulare-Kings Counties 5605 Hillsdale Drive Visalia, CA 93277 209/733-7643 (Dial 0)	C	Ford McGean Exec. Director 240-77-0046	Robert Howard 415/556-9110
XIV	Kern County PSRO, Inc. 1314 17th Street Bakersfield, CA 93301 805/327-3711 (8-984-1011 FTS)	C	Elaine Rabels Executive Director HSA-105-74-34	Karen Fuller 415/556-9116

Area		Status*	PSRO Contact	HEW Contact**
XVI	Organization for PSR of Santa Barbara-San Luis Obispo Counties 17 West Carrillo Santa Barbara, CA 93101 805/965-1066 (Dial 0)	C	James Webb Exec. Director HSA-105-74-87	Robert Howard 415/556-9110
XVII	Ventura Area PSRO 3585 Maple Street, Suite 232 Ventura, CA 93003 805/647-0750 (Dial 0)	C	Richard Michel Exec. Director HSA-105-74-32	Karen Fuller 415/556-9116
XVIII	Area XVIII PSRO 221 East Walnut, Suite 279 Pasadena, CA 91101 213/449-6919 (Dial 8)	C	Donald Miller Exec. Director 240-77-49	Helen Gookin 415/556-9126
XIX	Area 19 PSRO 853 Atlantic Avenue Long Beach, CA 90813 213/436-1256 (Dial 8)	P	Joanne Perler Exec. Director 240-77-55	Vona Poole 415/556-9132
XX	California Area XX PSRO 15250 Ventura Blvd. Suite 810 Sherman Oaks, CA 91403 213/995-0805 (Dial 8)	C	Lila Marcus Exec. Director 240-75-93	Fred Zentgraf 415/556-9112
XXI	PSRO of California Area 21 525 South Myrtle Avenue Suite 202 Monrovia, CA 91016 213/357-5031 (Dial 8)	C	Lorna Amundson Exec. Director 240-75-92	Helen Gookin 415/556-9126
XXII	Area 22 PSRO Suite 203 12301 Wilshire Blvd. Los Angeles, CA 90025 213/820-7031 (Dial 8)	C	Gerald Baldauf Exec. Director 240-75-86	Robert Howard 415/556-9110

Area		Status*	PSRO Contact	HEW Contact**
XXIII	California PSRO Area 23 Suite 100 23840 Hawthorne Blvd. Torrance, CA 90505 213/378-2248 (Dial 8)	C	Christopher Robson Exec. Director 240-75-97	Helen Gookin 415/556-9126
XXIV	Area XXIV PSRO Suite 1001 3450 Wilshire Blvd. Los Angeles, CA 90010 213/389-1267 (Dial 8)	C	Marvis Oehm Exec. Director HSA-105-74-210	Robert Howard 415/556-9110
XXV	Beverly Hills Area XXV PSRO Suite 308 7060 Hollywood Boulevard Hollywood, CA 90028 213/464-4355 (Dial 8)	C	Lois Kipp Exec. Director 240-77-32	Helen Gookin 415/556-9126
XXVI	Orange County PSRO 300 South Flower Orange, CA 92668 714/639-8801	P	Don Rosenthal Exec. Director HCFA-500-78-0026	Karen Fuller 415/556-9116
XXVII	Riverside County PSRO 6833 Indiana Avenue Riverside, CA 92506 714/686-0200 (8-796-1011 FTS)	C	Paul Parry Exec. Director HSA-105-74-36	Ken Hughes 415/556-9115
XVIII	San Diego-Imperial Counties PSRO 3702 Ruffin Road San Diego, CA 92123 714/565-8888		Howard Schmidt Exec. Director	Karen Fuller 415/556-9116

*Status:

C - Conditional
P - Planning

*HEW Address:

Division of Professional Standards Review
HSQB, HCFA, Region IX
100 Van Ness Avenue, 21st Floor
San Francisco, California 94102

PSROs
ATTACHMENT 6

CHRONOLOGY OF CRITICAL DATES IN CALIFORNIA-FEDERAL PSRO RELATIONS

August 23, 1974 - Meeting of M. Goran with State on MOU. State refused to sign MOUs until intent of law is clear.

February 24, 1975 - Secretarial clarification: Conditional PSROs found competent would exercise final authority on issues of medical necessity and quality of care for the purposes of claims payment for both Medicare and Medicaid.

July 1975 - Title XIX MOU between Redwood Coast PSRO and State signed.

January 21, 1976 - Letter from Under Secretary of HEW in response to letter from Director, California Deparment of Health, reaffirming HEW position.

March 1976 - Title XIX MOU between San Joaquin PSRO and State signed.

June 22, 1976 - SRS issued policy statement clarifying the involvement of State Medicaid agencies in the PSRO program (SRS-IM-76-27).

July 1976 - Title XIX MOU between Sacramento PSRO and State signed.

August 1976 - Title XIX MOU between Riverside PSRO and State signed.

December 1976 - Title XIX MOU between Kern County PSRO and State signed.

January 21, 1977 - Model MOU previously submitted by the State received Federal approval.

February 11, 1977 - Monitoring plan developed by State received Federal approval.

Spring 1977 - State alleged that its own staff shortages prevented timely consummation of MOUs based on approved model MOU.

August 1977 - Title XIX MOU between Santa Barbara PSRO and State signed.

September 6, 1977 - State presented a schedule to HEW for implementing MOUs with remaining conditional PSROs by the end of 1977.

October 1977 - State announced a moratorium (except with Santa Clara Valley PSRO) on implementing any further MOUs through June 1978, due to projected Medi-Cal budget overruns not attributable to PSROs.

December 1977 - Title XIX MOU between Santa Clara Valley PSRO and State signed.

January 11, 1978 - State instituted a federally approved plan to sign MOUs on a one-a-month basis beginning February 1978.

January 25, 1978 - State requested that all further MOUs include a requirement for 100-percent preadmission review.

January 30, 1978 - State agreed not to delay implementation of MOUs with San Francisco PRO and Area 23 PSRO and, instead, negotiate preadmission review as a modification.

February 16, 1978- Title XIX MOU between San Francisco PRO and State signed. Binding review to begin May. (100-percent preadmission review amendment considered separately.)

February 16, 1978 - Request from State to San Francisco PRO to include 100-percent preadmission review of elective admissions as method of concurrent review.

March 30, 1978 - Title XIX MOU between California PSRO Area 23 and State signed. Binding review to begin June 1, 1978. Requirement for preadmission review not included.

April 13, 1978 - A revised State monitoring plan and model MOU submitted to HEW for approval.

April 21, 1978 - State notified California PSRO Area 23 that preadmission certification must be performed on all elective admissions for 6 months, or MOU would be unilaterally abrogated (in violation of termination clause of MOU).

April 25, 1978 - Implementation of San Francisco PRO - Title XIX MOU delayed indefinitely under State threat not to honor MOU if PSRO will not perform preadmission review.

May 23, 1978 - State informed HEW it was processing its own data and in 6 months would be able to identify a focused list of procedures that PSROs could use to begin title XIX preadmission review.

June 9, 1978 - Revised State monitoring plan approved by HEW with qualifications.

June 15, 1978 - State requested by HEW to further revise model MOU.

June 30, 1978 - Addendum to MOU between PSRO Area 23 and State signed, establishing a three-hospital review pilot. Binding review began July 1, 1978.

June 30, 1978 - State refused qualifications of monitoring plan approval, declared an impasse and stopped any further negotiation of MOUs, except with Monterey Bay Area PSRO, where MOU was in process of being signed. Letter alleged that Congress did not want PSROs implemented quickly.

July 7, 1978 - MOU between State and Monterey Bay Area PSRO signed. Binding review began August 1, 1978.

July 13, 1978 - HEW and State agreed on two modifications to monitoring plan, which would break impasse. State to submit modifications within 2 weeks.

August 10, 1978 - Revised monitoring plan submitted, but substantially altered from agreement reached on July 13.

August 18, 1978 - State notified by HEW that revision of monitoring plan does not fulfill agreement reached on July 13.

August 21, 1978 - Eleven conditional PSROs ready to assume Medi-Cal review. Seven of them are willing to accept State preadmission review requirements. Six of them have been waiting for more than a year for a title XIX MOU.

REGION IX

DEPARTMENT OF HEALTH, EDUCATION AND WELFARE

HEALTH CARE FINANCING ADMINISTRATION

MEDICAID BUREAU

Fraud and Abuse Control

October-December, 1978

Participants: Phyllis Champion (RO/Program Integrity)
Linda DeCoss (RO/Program Integrity)
Apryl Williams (RO/Program Integrity)
Neil Merino (RO/Program Integrity)
Lorraine Skiff (RO/Program Integrity)

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FRAUD AND ABUSE CONTROL

I. Introduction

Fraud is a misrepresentation with the intent to obtain services, money, or other gain to which one is not entitled. Fraud is specifically defined by the laws of the appropriate Federal and State jurisdictions and the determination that fraud has been committed is made by a court of law. Typical examples of fraud are billing for a service that was not rendered, billing for a more costly service than that which was actually rendered, and false statements on an institutional cost report.

Abuse is used to describe practices which, although not fraudulent, may cause financial losses to the Medicaid program or to beneficiaries. Abusive practices will follow a pattern but lack either demonstrable intent or false statements. Abuse leads to a provider obtaining reimbursement to which he is not entitled under Federal and State laws and regulations. Typical program abuses include blatant overutilization of services, prescription splitting, gang visits, ping-ponging and overcharging.

Medicaid was designed as a Federal-State program which allowed the States maximum flexibility in financing the health care of the poor within broad Federal parameters. The original legislation left program administration and the maintenance of the program's integrity almost entirely to State discretion. As the years have passed there has been growing evidence that there has been too much State discretion which has resulted in unacceptable practices. It was decided that definition and enforcement of Federal minimum standards in both the programmatic and administrative areas was needed. As a result, though still very general, additional Federal requirements in the area of fraud and abuse control have been added to the Medicaid regulations.

On the Federal level the Office of Program Integrity was established in the recently created Health Care Financing Administration to provide oversite and monitoring of both Medicare and Medicaid fraud and abuse control activities. The Office of Program Integrity was created by merging the Program Evaluation Branch in the old Bureau of Health Insurance (Medicare) and the Division of Fraud and Abuse Control in the old Medical Services Administration (Medicaid).

Public Law 95-142, enacted October 25, 1977, provided authorization for independent State fraud control units to investigate and prosecute Medicaid provider fraud. Funding for these units is at 90 percent Federal financial participation (FFP).

As part of its role to assure that States employ appropriate remedies to control fraud and abuse in the Medicaid programs, the Office of Program Integrity, on a regional level, periodically assesses the status and effectiveness of such remedies.

Data presented in this chapter represents regional OPI analysis of California's fraud and abuse controls as they existed between October and December of 1978. The focus of this chapter is primarily on program administration and practices as they relate to Medicaid provider fraud and abuse. Recipient fraud and abuse are not addressed in any great detail.

II. Organization and Administration

The Department of Health Services, as the single State agency for the Medicaid (Medi-Cal) program, has overall responsibility for program administration. However, within the Department, the Medi-Cal Division is responsible for most day-to-day administration.

Responsibility for fraud and abuse control in the Medi-Cal program lies both in the Department of Health Services and the Office of the Attorney General. Exhibit No. 1 reflects the organization of the Department of Health Services. Within the Medi-Cal Division there are several units with various kinds of operational responsibilities which impact on fraud and abuse controls.

Fiscal Intermediary Section - Establishes policy and maintains liaison with fiscal agents (Blue Cross/Blue Shield).

Medi-Cal Intermediary Operations - Although not a part of the Department of Health Services, this outside contractor processes and pays Medi-Cal claims. Oversight is provided by the Fiscal Intermediary Section.

Recovery Section - Sets up accounts receivable and collects payments owed to the Medi-Cal program.

Prepaid Health Plans Section - Responsible for administration and monitoring of all prepaid health plan contracts.

Quality Evaluation Section - Performs medical and financial audits of prepaid health plans.

A. Fiscal Intermediary Section

The Fiscal Intermediary Section (FIS), a section within the Medi-Cal Division, through a series of operating instructions, directs the intermediary with respect to peer review and fraud detection activities. The instructions concern fraud and abuse by providers and recipients. Some of the responsibilities of FIS in the fraud and abuse area include directing all activities of the fiscal intermediary, testing computer systems via dummy files to assure integrity, handling complaints from recipients, and verifying the adequacy of internal security.

The Fiscal Intermediary Section is in the process of a reorganization due to the changeover from Medi-Cal Intermediary Operations to a new fiscal intermediary, Computer Sciences Corporation. The reorganization will merge FIS with the Medi-Cal Procurement Project, which will then have a combined staff of 85. In October of 1978, FIS was composed of 38 employees divided into three sections. The three sections were the Operations Unit, the Monitoring Unit, and the Administrative Unit.

The Operations Unit is the largest section. It is responsible for providing policy directives and operating instructions to Medi-Cal Intermediary Operations (MIO). The Monitoring Unit is responsible for analyzing performance and testing systems integrity at each intermediary. There is one analyst at each of the Blue Cross plans and two at Blue Shield. The Administrative Unit is responsible for special projects and the budget.

B. Medi-Cal Intermediary Operations

The State of California has contracted with Blue Shield of California, Blue Cross of Southern California and Blue Cross of Northern California to process and pay Medi-Cal claims. These organizations have formed Medi-Cal Intermediary Operations. The two Blue Cross plans process institutional provider claims and Blue Shield processes professional provider claims. Each of the plans has authority to make payment adjustments and to take providers on or off special review.

C. Recovery Section

The Recovery Section, a section within the Medi-Cal Division, is responsible for setting up accounts receivable and collecting payments that are due the Medi-Cal program whether from insurance carriers, recipients, or providers.

As of September 1978, the Recovery Section had a staff of approximately 87 people. For the fiscal year ending June 30, 1978, the Recovery Section had collected $11.6 million. The Recovery Section expects to staff up to 141 positions during the 1979 fiscal year; it anticipates collecting approximately $16 million in overpayments.

The headquarters office is in Sacramento. Field offices are located in San Francisco, Hollywood, Santa Ana, and San Diego.

The Recovery Section is divided into three units: the health insurance unit, the casualty insurance unit, and the compliance unit. Both the health insurance and the casualty insurance units collect money due the Medi-Cal program from insurance carriers and other third-party payors. The compliance unit, which has a staff of 37, collects money from recipients and providers. The compliance unit receives accounts for collection from other sections including the Investigation Section, the Surveillance and Utilization Review Section, Audits Branch, the Alternative Health Systems Branch, Legal Services, and county welfare departments.

The Compliance Unit is essentially a collection agency. When one of the investigative agencies, for example, the Investigation Section or the Surveillance and Utilization Review Section, sends a demand letter to a provider, a courtesy copy is sent to the Compliance Unit. The Compliance Unit then sets up an account receivable. The Compliance Unit has the responsibility to review the demand letter for correctness and completeness and to verify that the demand letter shows the correct dollar amount, that it has been sent within the correct time frame, and that the overpayment was correctly established.

D. Prepaid Health Plans Section

This section assists prepaid health plans in their day-to-day operations. It receives complaints from dissatisfied recipients who wish to disenroll from plans. It also assists plans in complying with all Department of Health requirements.

E. Quality Evaluation Section

This section performs financial, administrative, and management audits of prepaid health plans. These audits are independent of any monitoring that is done by the Prepaid Health Plan Section.

F. Audits and Investigations Division

More direct responsibility for provider fraud and abuse controls within the Department of Health Services rests with the Audits and Investigations Division. The Deputy Director for Audits and Investigations reports directly to the Director of the Department of Health Services.

As reflected in exhibit No. 1, Audits and Investigations includes a number of branches. For purposes of this chapter review was made of the Investigation Section and the Surveillance and Utilization Review Section. Activities of other branches are interfaced in this report as appropriate.

1. Investigation Section

The Investigation Section has existed in the Department of Health Services in different forms since December of 1967. It has responsibility for investigating recipient fraud to conclusion. For provider fraud, the Investigation Section, under an agreement with the Medi-Cal Fraud Unit, substantiates allegations by conducting preliminary investigations. If fraud appears to exist, referral is made to the Medi-Cal Fraud Unit for investigation and/or prosecution.

a. Staffing and Budget - The Investigation Section functions organizationally through four field offices and headquarters in Sacramento. (See exhibit No. 2).

There are currently 55 positions in the Investigation Section. Twenty-seven positions were lost to the Medi-Cal Fraud Unit and thirty-two because of CETA cuts.

The headquarters office is staffed by the chief, deputy chief, and one investigator plus clerical staff. Headquarters is responsible for the overall management of the Investigation Section and for establishing policies and controls. Headquarters publishes the Investigation Section's manual which details policies and procedures. There are four field offices: San Francisco, Fresno, Los Angeles, and Santa Ana. The Los Angeles office has three supervisory investigators. Each of the other three offices has one supervisory investigator. There are two regional supervisors: one for northern California, and one for southern California. The northern California regional supervisor is responsibile for the San Francisco and Fresno offices; the southern California regional supervisor is responsibile for the Los Angeles and Santa Ana offices. Under the field offices are several resident stations in various locations. The regional supervisor exercises fairly wide latitude and autonomy in managing his territory.

The Investigation Section receives over 900 complaints each month. The branch has a fiscal year 1978 budget of over $1.1 million. The previous fiscal year budget was approximately the same.

b. Primary Activities - The Investigation Section is responsible for the following:

*Review and analysis of complaints at the field level from the following sources:

1. Providers of Service
2. Patients
3. County Welfare Departments
4. Law Enforcement Agencies
5. Other Department of Health Units
6. Fiscal Intermediary
7. Licensing Boards
8. The Public

*The conduct of field investigations (preliminary and full-scale investigations for recipient; preliminary investigation only since July 1978 for providers).

*Preparation of cases for prosecution (recipients), administrative action, or other disciplinary action.

2. Surveillance and Utilization Review Section (SURS)

The Surveillance and Utilization Review Section of the Audits and Investigations Division of the Department of Health Services was formed in November of 1976. The section identifies Medi-Cal provider and recipient fraud and abuse and takes corrective action where indicated. Their goals include insuring that only medically necessary and appropriate Medi-Cal services are provided at the lowest cost, and encouraging utilization control by referring providers practicing substandard medicine to local medical associations and peer review committees.

The SUR Section is organized into a headquarters office and two regional offices. The SURS chief and administrative staff, including the chief medical advisor, are headquartered in Sacramento. Actual case development is performed in the regional offices, which are divided on a geographical basis with offices located in San Francisco (for northern California) and Los Angeles (for southern California). The regional offices are staffed with medical personnel and program analysts who work together on provider reviews. The staffing of the SURS offices is shown on exhibit No. 3. Although there has been a statewide hiring freeze, SURS has received an exemption to fill the eight vacant pharmacy positions. This would leave 23 vacancies. However, if Title II funding (positions with asterisks on exhibit No. 3) is not extended, the people who currently fill Title II positions will be placed into the vacant, regularly budgeted positions. Current plans call for two of the vacant Nurse II positions to be transfered to Sacramento and filled there. It is anticipated that staffing plans will be finalized by February 1, 1979.

G. Medi-Cal Fraud Unit

The passage of Public Law 95-142 made available Federal funds to staff independent units to investigate and prosecute all types of Medicaid fraud in the administration of the program and in the provision of medical assistance. This unit in California is located in the Office of the Attorney General (exhibit No. 4). The unit was certified effective July 1978. It consists of a central office and four regional offices (exhibit Nos. 4A and 4B). Current approved staff is for 59 positions. The current annual budget is approximately $4.5 million.

The central office is in Sacramento and houses the Chief of the Unit, the Chief Investigator, and the Analyst. The proposal for funding anticipated the hiring of a Complaint Clerk; this position had not been filled at the time of our review.

The four regional offices are located in Sacramento, Los Angeles, San Francisco, and San Diego. Staffing of the regional offices on October 24, 1978, was as follows:

Region	Attorney	Supervising Investigator	Investigator	Auditor
Sacramento	1	1	3	1
Los Angeles	3	2	7	1
San Francisco	1	1	3	1
San Diego	1	1	4	1

Relationships with the Investigation Section and SURS (the primary State agency sources of referrals to the unit) are still forming. A joint memo (exhibit No.5) between the chiefs of the Medi-Cal Fraud Unit and the Investigation Section was issued on July 31, 1978. This memo outlines the procedures to be used by both offices in referring complaints involving potential Medi-Cal fraud.

In summary, there are two distinct departments within the State which have the responsibility for the overall control of fraud and abuse in the Medi-Cal program:

1. the Department of Health Services and its several divisions, and
2. the Office of the Attorney General.

Exhibit No. 6 details the major fraud and abuse control activities and shows organizational units which have primary responsibility for each.

III. Fraud and Abuse Detection and Prevention

Potential cases of fraud and abuse come to the attention of the Audits and Investigations Division (Investigations and SURS) in a number of ways. For this portion of the report, detection methods are classified as either claims processing or nonclaims processing.

A. Claims Processing

1. Medi-Cal Intermediary Operations

The processing of Medicaid claims in California is currently handled for the most part by Medi-Cal Intermediary Operations (MIO), a company comprised of Hospital Service of California (Blue Cross - North), Hospital Service of Southern California (Blue Cross - South), and Blue Shield of California. The MIO system is designed to accept, control and process Title XIX claims and those Title XVIII claims involving recipients entitled to both Medicare and Medi-Cal.

The claims review and processing system of the fiscal intermediary is the major source of information through which program abuse by providers or beneficiaries should be able to be identified. The Fiscal Intermediary Section of the Medi-Cal Division has issued a number of operating instructions to MIO regarding peer review and fraud detection responsibilities. The communications identify priorities for detection, and outline procedures for referral of leads, complaints, and suspicion of program abuse. They also specify actions to be taken.

In an MIO operating instruction from the FI Section issued in 1975, MIO was instructed to prioritize its levels of review in terms of suspicions. Exhibit No. 7 explains how MIO is to handle suspicions of program abuse discovered in the claims processing system.

a. Review Activities

Key personnel at MIO Liaison and Blue Shield were unable to cite specific DOH instructions dealing with the detection and handling of potential fraud and abuse situations. There are some general DOH instructions on fraud and abuse, but these date back at least two or more years. MIO does have mechanisms for referring potential fraud and abuse cases. Exhibit No. 8 reflects 1977-78 referral activity.

Each plan has an audit/medical review section. Most review is done on a postpayment basis via analysis of computer generated exception reports. There are also numerous edits and screens built into the automated claims processing system. For example, institutional claims are matched against professional claims to detect possible duplicate billings. However, from an abuse protection standpoint the capacity to detect patterns of billing aberrations, overutilization of services, or services not rendered is greatest at the postpayment level. Of course, once a provider has been identified as a problem, a prepayment review of claims can be initiated.

For the most part the MIO relies on peer group norm exception reports. These reports compare providers on a similar basis and can show a wide variety of utilization and billing patterns. Blue Shield had used the SUR system reports. But after expending two employee years analyzing 6,000 reports, only 2 abuse cases were generated.

At Blue Shield of California, analysts in the Utilization and Audit Review section analyze peer group norm reports for such things as patterns of treatment or services, repeated diagnoses which do not appear appropriate, services not warranted by the diagnosis, or a large number of visits or services in one day. Other situations captured by these exception reports which might indicate possible fraud or abuse are upgrading of RVS values which are not compatible with a given diagnosis, unwarranted surgeries such as large numbers of hysterectomies or cataracts, or billing individual components for panel lab work or X rays. The range of situations which can be observed is virtually unlimited.

At the Blue Cross plans a wide range of reports are available which compare selected billing and utilization data. Provider length of stay data, ancillary charges, emergency room charges, and admission and discharge data can be compared in various configurations. Nurses or other trained personnel review the exception printouts and selected claims.

b. Relation to the Investigation Section

Medi-Cal Intermediary Operations receives no direct instructions from the Investigation Section. Direct contact between MIO and the Investigation Section relates to specific cases or investigations. The Investigation Section may contact the plans directly for information relating to a case. Also, MIO refers cases to the Investigation Section directly. Most leads are referred to the appropriate Investigation Section Field Office. During calendar years 1977 and 1978, MIO referred 101 leads to the Investigation Section.

All Investigation Section requests for information must be in writing. A form letter is used for this purpose. MIO can respond to a request for information within one to two weeks.

c. Relation to Surveillance and Utilization Review Section (SURS)

There is a substantial exchange of information between SURS and MIO. SURS has the capability to immediately retrieve utilization information and beneficiary histories from MIO via CRT. During calendar years 1977 and 1978, MIO referred 2,474 cases to SURS compared to 101 cases referred to the Investigation Section during the same period.

The reason for this wide disparity in referrals is that MIO refers only suspected fraud cases to the Investigation Section. Fraud is a much narrower category than abuse. Additionally, MIO assumes a very narrow definition of fraud. For example, MIO will refer a suspected case of billing for services not rendered or duplicate billings not attributable to denial error to the Investigation Section. On the other hand, upgrading of RVS codes is generally regarded as an abuse and would be referred to SURS.

SURS also provides direction to MIO on review activities. Approximately one-third of providers on medical review have been put on at the request of SURS. SURS may direct MIO to place a provider on either prepayment or postpayment review. Usually when a provider is placed on prepayment review by Blue Shield, the provider is given two weeks' notice. This is a longstanding policy at Blue Shield. Blue Shield requested and was granted this authority from SURS. No such notice is given to a provider placed on prepayment review for Medicare.

d. Medi-Cal Bulletin

Medi-Cal Intermediary Operations issues bulletins to professional and institutional providers in California. These bulletins discuss Medi-Cal policy and claims processing directions. The subject matter may be suggested either by DOH or MIO and the final draft must be cleared through FIS. MIO Liaison will not issue any bulletin covering fraud or abuse unless directed to do so by FIS.

During 1978 there were two bulletins that pertained specifically to fraud and abuse activities. The first of these bulletins (Medi-Cal Bulletin No. 82, printed in April 1978) listed suggested Department of Health disciplinary sanctions for violations of various sections of Title 22 of the California Administrative Code. The other bulletin (Medi-Cal Bulletin No. 87, July 1978) contained a listing of providers suspended by the Department of Health. This bulletin was initiated by the Investigation Section through FIS. No bulletin was published during 1978 regarding the provisions of Public Law 95-142, the Fraud and Abuse amendments commonly known as H.R. 3.

2. MMIS-SURS

California has a certified MMIS. It is the responsibility of Surveillance and Utilization Review Section (SURS) of the Audits and Investigations Division to conduct reviews of data generated by the S/UR Subsystem of the MMIS. A description of the SURS Unit was provided under Part II of this chapter.

SURS receives cases from several sources:

Department of Health Units such as Field Services, Investigation Section, and Audit Branch;

Fiscal Intermediary;

Beneficiary Explanation of Medi-Cal Benefits (BEOMB) system;

Beneficiary Complaints;

Anonymous Complaints;

Peer Group Referrals;

Other Providers;

Other SUR Units;

HEW; and

Other Government Agencies.

The greatest volume of cases is received from the fiscal intermediary. Reports are received about exceptor/providers from the S/UR Subsystem of the MMIS. However, most of the current S/UR reports are unusable and MIO has made few improvements. The only reports being used to identify abuse are the drug report (DUR 135) and the PGN report (UM80/81). The PGN report lists procedure codes by provider and flags the ratio per 100 patients. If the billing for an RVS code exceeds the mean plus two standard deviations, the provider is flagged for referral to SURS. Each SURS field office receives approximately ten PGN reports per month. Additionally, another ten or so are ordered on cases received from other sources. The PGN reports are reviewed and prioritized. If the PGN flags are significant and sufficient dollar volume is involved, the provider is scheduled for review.

SURS determines whether or not the case is appropriate for further review. To make this determination SURS screens its referrals to make certain that they fall within the appropriate statutory jurisdiction. For example, referrals involving quality of care would be sent to the Board of Medical Quality Assurance, as that is its jurisdiction. All referrals involving abuse would be assigned a case number, designated a work priority, and logged for further action.

On those cases where the nature of the abuse and dollar volume are sufficient to warrant review, desk audits are performed by the SURS analyst who orders fiscal intermediary reports and/or provider claims to provide working information for a possible on-site review. These reports provide detailed information regarding the patterns of services discussed in a complaint or referral. When an aberrant billing practice is detected, an on-site review is conducted. All cases that go to on-site review receive a full-scale investigation at the provider's premises;

however, priorities are set for cases to go to on-site review:

Priority 1: cases which may involve unnecessary or dangerous procedures that may harm or jeopardize the patient's physical or mental health or social adjustment;

Priority 2: cases that appear to involve a large-scale abuse with the receipt of sizable amounts of Medi-Cal funds;

Priority 3: cases that do not involve dangerous medical practice or high dollar volume; and

Priority 4: random-sampling cases selected by SURS.

The SURS team, consisting of a medical specialist and a program analyst, performs the on-site review during which they ". . . examine Medi-Cal patient records, charge slips, remittance invoices, etc. Also, the team members may request copies of fee lists, policy statements, etc. The team also makes a brief tour of the facility to evaluate the equipment, building, and staffing available to treat Medi-Cal patients." These records are evaluated to determine the appropriateness, adequacy, and reasonable cost of provider services, in accordance with Medi-Cal regulations. If the team identifies over-utilization, misuse, or fraud in the Medi-Cal program, the team ensures that proper action is taken.

Disposition of Cases

If during the course of this review, apparently fraudulent conduct or practice is evident, SURS makes a referral to the appropriate Health Investigations District Supervisor who may in turn refer the case to the Fraud Unit in the Office of the Attorney General for action.

If the review confirms an aberrant billing practice, although not fraudulent, certain administrative remedies are available:

Prospective Review: Prepayment review by a Fiscal

Intermediary advisor without additional medical documentation.

SPEAR: Special Prepayment Evaluation and Review - Prepayment review by a FI advisor, along with the medical justification for the services rendered.

Prior Authorization: The provider must obtain approval for certain specified services before medical coverage is approved.

Recovery: Projected - Recovery of Medi-Cal monies based on a statistical sample of the total services paid to a provider.

Pursuant to Welfare and Institutions Code 14124.2, any records obtained from providers during the on-site review are destroyed when administrative actions are completed.

The SURS Weekly Case Tracking Report is the basis for monitoring the progress of any case through the SUR system. This report lists all SURS cases by provider name. It indicates the referral date and other information concerning the case's progress through each step of the SURS process.

The SURS statistical reports (see exhibit No. 9) contain an analysis of case actions by provider type. They enable management to assess the unit's case output for the month. They include a rough estimate of dollar savings over a one year period. (The method of computing this "fiscal impact" is in the process of being refined.) Each SURS office completes the "SURS Monthly Statistical Report." The statistics from this report are combined on a quarterly basis into the SURS Quarterly Activity Report. The headquarters analyst reviews and combines these regional reports into the composite SURS report. The SURS Weekly On-Site Review Report shows which cases are currently undergoing on-site review. These reports are prepared by the field offices and telecopied to headquarters the last working day of each calendar week.

Additionally, SURS sends reports of cases and activities to HCFA, OPI in accordance with an agreement between the two agencies.

Recommendations:

SURS

a. It appears that any reduction of staff would adversely affect the number of cases the unit is able to investigate. Efforts to retain current staffing allocations should be initiated in order to assure adequate emphasis on overutilization of services as well as misutilization.

b. While SURS has been very successful in identifying cases for review, better use could be made of the S/UR Subsystem of MMIS. SURS should continue to work with Computer Sciences Corporation (new fiscal intermediary) to perfect the reports generated by the S/UR Subsystem. Improved exception reports should increase the productivity of the SURS staff by providing more accurate and productive data for analysis. Reports such as the attached "Cost Avoidance from SPEAR" (exhibit No. 9C) should be automated by CSC and provided to SURS promptly at the end of each fiscal year.

c. Records obtained from providers should be maintained by the State for not less than one year in order to insure their availability in cases of provider grievances or complaints. Maintenance of this data will assist HEW to assure the correctness and verification of SURS reports. (See 1902(a)(6) of the State plans for Medical Assistance.)

d. Both in reviewing SURS own reports and in participating in special HEW projects, it is noted that a heavier workload (cases received) is borne by the Los Angeles Regional Office. SURS should review the staffing between its field offices to assure an equitable emphasis on provider abuse throughout the State.

B. Nonclaims Processing

Allegations of potential fraud and/or abuse instances can be received from public complaints or through EOB verification.

1. Public Complaints

Such complaints account for the majority of all allegations referred to the Investigation Section for preliminary review. Complaints come from a variety of sources:

a) county welfare departments,
b) providers and their employees,
c) beneficiaries and relatives, and
d) the public in general.

2. EOB Verification

a. Description

The State of California's Department of Health Services (DHS) employs the Beneficiary Explanation of Medi-Cal Benefits (BEOMB) statements as a means of verifying services billed to the Medi-Cal program. The first run of statements was mailed to Medi-Cal recipients in 1977. At that time sensitive services, i.e., VD treatments, drug abuse service, etc., were not screened from the mailing, and resulted in disclosure of confidential patient information problems. The issuance of BEOMBs was halted at that time. The program was reinstituted in January 1978. "Sensitive services" are not being verified in the modified program.

The administration of the BEOMB program had been the responsibility of Department of Health's Medi-Cal Operations Branch up until three weeks prior to the P.I. Assessment. The BEOMB program is now administered by the Department of Health's Surveillance and Utilization Review Section. Presently, the program is assigned to a SURS specialist who is compiling various reports in order to maintain statistics on the progress and productiveness of the program. The function of receiving and sorting the BEOMB is still being performed by Medi-Cal Operations Branch but is to be transferred to SURS.

BEOMBs are mailed monthly to a random sample of two percent of the total recipients receiving Medi-Cal services. From the total sample, the names of deceased beneficiaries and those having received "sensitive services" are deleted. The BEOMB statement is a 3 1/2- by 7-inch card on which those services paid by Medi-Cal to a provider for that particular recipient are printed. It requests that the recipient indicate any discrepancies between the services he received and those paid. The recipient is asked to mail the card to the address shown on the card. The average number of BEOMBs mailed monthly is approximately 25,000. They are mailed on the 15th of each month. The average rate of nondeliverable BEOMBs for the months of January through August 1978 ranged from 2.01 percent to 3.96 percent. The reason given is that these individuals have moved and either did not notify their eligibility worker of their new address or the address change had not yet been processed. Those BEOMBs returned as nondeliverable are destroyed; no further action is taken to locate these recipients.

The BEOMB asks that recipients respond only if they did not receive the services printed on the card. The average response rate of the BEOMB program per month runs from 1.37 percent through 2.39 percent. Of these, approximately 50 percent verify that the services were rendered. The remainder result either in referrals or contain requests for information and other Medi-Cal business. Therefore, only 0.35 percent to 0.14 percent of the BEOMB responses resulted in referrals to Investigations and SURS. As of May 1978 the Investigation Section stated that it has been unable to substantiate any of the referrals. Only 1 of the 11 BEOMB referrals made to the Investigation Section has resulted in a recovery of Medi-Cal monies. SURS is experiencing similar results. In September SURS reported that 8 out of 362 referrals contained information relating to the Medi-Cal program. During an interview with the Los Angeles SURS Unit, it was found that those referrals relating to the Medi-Cal program rarely contained any issue relating to fraud or abuse. This seems to be happening even though BEOMB responses are screened for pertinent referrals by the BEOMB processing unit before sending them on to SURS or the Investigation Section.

In a move to improve the type of responses from the BEOMB program, an attempt was made to make the BEOMB easier for the recipient to understand. For example, general definitions of rendered services have been changed to more definitively describe the service received (i.e. "Dental" has been changed to "Dental X-Ray", "Dental Filling", etc.). Also, discussion has taken place to determine how to increase the number of BEOMB responses, but this was prior to the transfer of the BEOMB program to SURS.

Some of the ideas considered were: (1) to enclose a stamped self-addressed return envelope with the BEOMB; and (2) to establish a unit to handle referrals by phone and to print the phone number on the BEOMB. Both of these ideas, according to the State, would be too costly and would not necessarily result in more fraud and abuse referrals.

Field eligibility workers have been trained to lend assistance to recipients who have questions about a BEOMB which may have been received. Field staff know where to send misdirected BEOMBs that may come into the field offices.

The State of California BEOMB system generates a large number (an average of 25,000) of verification statements monthly. The rate of nondeliverables is relatively small; however, the rate of beneficiary response is also low. Usually half of those responses received by the State verify that the services billed were rendered. The remainder discuss a gamut of Medi-Cal issues, with even fewer involving fraud or abuse referrals. The amount of resources that have been and continue to be spent seems to warrant that continued effort be put to finding ways to increase the rate of beneficiary response and to elicit the right kind of response - that of fraud and abuse referrals. The BEOMB system is not producing the fraud or abuse referrals that were expected. Our recommendations are as follows:

b. Recommendations

1) The Department of Health Services should reevaluate the language on the BEOMB so that recipients can better understand what is expected of them and more readily identify those services printed on the BEOMB.

2) DHS should examine ways to make it easier for the beneficiary to return the BEOMB as a reporting mechanism. For example, enclosing a preaddressed envelope or having the return address preprinted on the BEOMB.

3) DHS should consider whether the sampling system could be programmed to screen out deceased recipients and sensitive services before the 2-percent sample is selected. This would increase the actual number of BEOMBs mailed for verification of Medicaid services.

4) DHS should reevaluate the screening process of those BEOMB responses which are received in order that more appropriate responses are forwarded to SURS and to the Investigation Section.

IV. Routine Audits

The Audit Branch of Audits and Investigations Division of the Department of Health Services has audit programs for making field audits of both skilled nursing facilities and hospitals. Each of the audit programs contains steps which could identify fraudulent claims for expenses. For example, the skilled nursing facility audit program contains an audit step for the review of expenses:

> "Analyze in terms of improper accruals, unallowable expenses, revenue abatements, and personal comfort items."

The audit program for hospitals contains an audit step for reviewing the methods of accounting for revenues and expenses of affiliates when the hospital is an interrelated entity.

According to the Chief of the Audit Branch, each auditor is instructed to discuss any potential fraud items with the audit supervisor. Cases are then referred from the Audit Branch to the Investigation Branch for a full scale fraud investigation. About two referrals per month are made to Investigations for potential fraud and abuse based upon an audit of a provider's records.

V. Investigations

Prior to the certification of the Medi-Cal Fraud Unit under Section 17 of Public Law 95-142, provider as well as recipient fraud investigations were conducted by the Investigation Section of the Audits and Investigations Division of the Department of Health Services.

Responsibility for conducting full-scale investigations now rests with the Medi-Cal Fraud Unit in the Office of the Attorney General. Preliminary screening of allegations is the responsibility of the Investigation Section. Exhibit No. 5 details the agreement between the Investigation Section and the Medi-Cal Fraud Unit by which referrals are to be made from the Investigation Section to the Medi-Cal Fraud unit.

It should be noted that, though the Medi-Cal Fraud Unit has the primary responsibility for conducting full-scale fraud investigations, the Investigation Section did retain a few cases after July 1, 1978, because such cases were almost ready to be filed with the district attorney.

A. Investigation Section, Department of Health Services

The Investigation Section receives over 900 complaints each month.

1. Workload

During the month of September 1978, 948 complaints were received. At the end of the month there were 3,241 preliminary investigations and 976 cases pending statewide. With 32 investigators this averages out to 101 preliminary investigations and 30 1/2 cases per investigator. (A "case" can be roughly defined as a full-scale investigation.) At the close of the 1978 fiscal year, there were 3,052 preliminary investigations and 986 cases pending. At the close of the previous fiscal year, there were 3,268 preliminary investigations and 1,361 cases pending. During September, 578 preliminary investigations and 99 cases were closed. A sum of $135,880 was identified for recovery, mostly by the Los Angeles field office. Exhibit No. 10 reflects significant activity of the Investigation Section during fiscal year 1978.

2. Case Organization

Case organization was generally good. In all three field offices the reports of investigation generally provided a very good summary of investigative activity. In the Los Angeles office they were uniformly excellent.

In all three offices, the older, more voluminous cases tended to suffer somewhat from drop-filing of documents in that memoranda were sometimes out of sequence. In all three field offices, investigator notes and reports of contact are routinely omitted from the permanent file. Once a report of investigation is written, the investigator's notes are usually destroyed. In closed cases, only the report of investigation remains, plus file copies of subsequent transmittal letters to headquarters or to the District Attorney or Attorney General's office.

In none of the field offices is there any set format for pending investigator files. Each investigator exercises complete control over the organization of his or her pending files. No running summary or fact sheet is maintained on either individual investigator files or office files.

3. Case Development

A number of cases were reviewed at each of the field offices. The majority of cases reviewed appeared to be properly handled, although some cases had excessive delays between actions. Timely follow-up was a problem at each of the offices. However, each office suffers from a heavy investigator caseload. In the San Francisco office there was a large number of preliminary investigations over one year old. That office is trying to close out all preliminary investigations over six months old by early 1979.

The Investigation Section has a fairly aggressive posture in seeking criminal penalties against most violators. The one notable exception is in recipient failure to disclose income or assets: if the amount of Medi-Cal funds involved is under $750, the Investigation Section will request recovery only. Recipient fraud is usually treated as a misdemeanor, whereas provider fraud is usually treated as a felony.

4. Priorities for Determining Case Selection

Each investigator has a good degree of autonomy in managing his workloads. The investigator has responsibility for deciding the order in which cases will be worked and the amount of time spent on each. The Investigation Section statewide receives over 900 cases per month. Of these, only 100 per month can be worked. Therefore, some system of priorities had to be worked out. Headquarters decided to let investigators select their own cases from those assigned. However, each district office is rated by two standards: (1) the number of investigations closed and (2) the results of those cases, i.e., the case disposition.

Headquarters has devised a rating system to determine the effectiveness of each of the district offices. The system is based on four areas of activity: (1) the number of criminal actions filed, (2) the number of administrative actions filed, (3) the amounts identified for recovery of overpayments, and (4) the number of warning letters written. A score of 25 points is assigned to the first category, criminal actions filed; a score of 20 points is assigned to the second activity, administrative actions filed; a score of 1 point is assigned for each $1,000 of overpayment identified; finally, a score of 2 points is assigned for each warning letter. These are added up at the end of each month for each office and divided by the number of man-hours. This information is furnished to the field offices so that each office is aware of the ratings of the other offices.

This rating system is not set up to measure individual investigator performance. Headquarters will be aware of how each of the field offices is performing and can monitor the field office as a whole. It is left to the supervisors to assess the investigators. Supervisors are expected to know which investigators are performing less adequately than others and to take appropriate training action to remedy the situation. This rating system has been in effect for approximately five years. The chief of the Investigation Section points out that this is one of several alternatives that had been considered. One alternative was to spell out in detail what the investigator should look for in determining whether or not to open a case and how much time to give to a case. Although there are some guidelines in the "Investigation Section Manual" for determining the priority of a case, headquarters has allowed the investigators much discretion. It is the headquarters policy to specify the results that they want to achieve and to let the investigators and the individual field offices decide how to obtain those results.

5. Beneficiary Explanation of Medi-Cal Benefits (BEOMB) Program

For the month of September, 38 referrals were received statewide from the BEOMB program. However, the BEOMB program has been a failure in terms of providing quality referrals. All three field offices indicated that they had had high expectations of the BEOMB program. There has been a problem with the quality of the BEOMB printout itself. The BEOMB suffers from misinformation and poor wording. For example, prescription drug numbers are often wrong. Also, the BEOMB simply shows "pharmacy" rather than "tetracycline," or "radiology" instead of "X-ray." The BEOMB may show payment made to a given doctor while the printout from Medi-Cal Intermediary Operations shows payment was made to an entirely different doctor. Still another problem with the BEOMB program is that a recipient may complain that the physician took two Medi-Cal stickers, but the investigation will show that one sticker was for the office visit and the other sticker was for laboratory work. (This would be a proper use for the two stickers.)

6. Relation to Medi-Cal Fraud Units

When the Medi-Cal Fraud Unit was established, the Investigation Section referred 180 preliminary investigations. This was at the end of June of 1978. In July, 63 preliminary investigations were referred; in August, 61 were referred; and, in September, 56 were referred.

Relationships with the Medi-Cal Fraud Unit are still forming. A joint memorandum by the chiefs of the Medi-Cal Fraud Unit and the Investigation Section was issued on July 31, 1978. This memorandum outlined the procedures to be used by both offices in referring complaints involving potential Medi-Cal fraud.

Each Investigation Section field office is developing its own relationship with the parallel Medi-Cal Fraud Unit regional office. For example, in San Francisco the Investigation section office and the Medi-Cal Fraud Unit have established supplemental instructions for referring cases.

Despite the agreement reached between the Medi-Cal Fraud Unit and the Investigation Section, the chief of the Medi-Cal Fraud Unit feels there are some problems with the quality of referrals made by the Investigation Section. Medi-Cal Fraud Unit has pointed out that there is no incentive for an individual investigator in the Investigation Section to spend any significant amount of time developing a provider case, since he gets his "credit" for beneficiary cases closed. This problem, however, is not unique to California. It is apparently being experienced in other states where Medicaid fraud control units exist. The Office of Program Integrity, Office of Investigations, and the Medicaid Bureau will be addressing this issue with the State agency and the Medi-Cal Fraud Unit in the near future.

7. Relation to Surveillance and Utilization Review Section

The Surveillance and Utilization Review Section has periodically sent referrals to each of the field offices. However, the volume of referrals has been low. The Los Angeles field office receives a monthly listing of anticipated on-site reviews from the Surveillance and Utilization Review Section field office. The field offices occasionally serve subpoenas and suspension notices for the SURS field offices.

8. Relation With FBI

The Investigation Section does not have an ongoing relationship with the FBI. However, from time to time personnel from the FBI have dropped by the Investigation Section to ask for referrals. Usually the Investigation Section has complied with such requests and has furnished leads. However, the Investigation Section chief noted that the FBI has never provided feedback on any referrals. For example, there was a recent case that was referred to the FBI by headquarters; the FBI investigated the case, and the provider was tried and convicted in Federal court. The Investigation Section learned of the status only after reading about the conviction in the "Sacramento Bee." When the Investigation Section contacted the FBI for a copy of the investigative report, the FBI refused, saying that the Investigation Section would have to make a written request to the U.S. attorney. This was so even though the information was on public record and in spite of the fact that the FBI had received the lead from the Investigation Section.

Although the Investigation Section has provided information directly to the FBI upon request and has spent time with FBI personnel explaining Medi-Cal regulations, a protocol was established among the Attorney General's office, the Inspector General's office, and the HEW Secretary's office in which it was decided that the Office of the Inspector General would be the liaison for any Medicaid criminal investigative agency. In California, the Office of Investigations was to be the liaison and sole contact for criminal case referrals. The chief of the Investigation Section prefers that this protocol be carried out. The Investigation Section contacted the director of Office of Investigations to clarify the issue. The Office of Investigations confirmed that it was, in fact, the liaison for other Federal investigative agencies.

9. Relation to the Office of Program Integrity

The Investigation Section operates independently from the Office of Program Integrity. Medicaid cases are handled as solely Medicaid cases unless development clearly indicates Medicare involvement. If a complaint is received and an initial review of the complaint indicates that there is primarily Medicare involvement, the case is referred to the Office of Program Integrity. The chief of the Investigation Section indicated that, when his office receives information from Medi-Cal Intermediary Operations, the printout shows only Medi-Cal information. It does not show any Medicare information. The result is that, even though there may be some Medicare involvement, the Investigation Section will be dealing with only Medi-Cal and would not be in a position to know of concurrent Medicare activities or involvement unless this is specifically developed in the course of the investigation.

10. Relation to PSROs

A year ago the headquarters office issued a memorandum to all Professional Standards Review Organizations informing them of their responsibility to report incidents of potential fraud or abuse. That memorandum was dated September 13, 1977. To date, no referral has been made by any PSRO.

11. Professional Relations

The Los Angeles field office has developed some innovative provider relations programs. For example, 65 high-volume emergency rooms were singled out in the L.A. metropolitan area. A meeting was held with the emergency room director and selected staff at each of those hospitals to encourage identifying and reporting Medi-Cal violations. (The most common violations include a patient using a Medi-Cal recipient's card or a Medi-Cal recipient indicating employment or other medical coverage on the emergency room application.) These presentations generated a number of referrals.

The Los Angeles office also contacted each of the Los Angeles County welfare departments that handle Medi-Cal applicants. A presentation was made to the director and supervisors regarding the identification and reporting of suspected Medi-Cal violations. A liaison or key contact person has been established at each of the county welfare offices. An acknowledgement letter is routinely sent to the eligibility worker; a disposition letter is sent when the complaint is closed.

12. Recommendations

The Department of Health Services should review and, if necessary, revise existing procedures and Memorandum of Understanding with the Fraud Control Unit to ensure that all referrals to the FCU meet mutually acceptable minimum standards.

B. Medi-Cal Fraud Unit (Office of the Attorney General)

The Medi-Cal Fraud Unit, located in the Office of the Attorney General, is charged with the responsibility of investigating fraud in the administration of the program and in the provision of medical assistance. The Unit was certified, effective July 1, 1978, pursuant to 42 CFR 450.310(d)(1). It consists of a central office and four regional offices. Exhibit Nos. 4, 4A, and 4B describe the Unit's organization and staffing patterns.

1. Workload

There were 334 cases pending on September 30, 1978. The following chart shows the cases pending for each regional office and the caseload per working investigator/auditor:

REGION	CASES PENDING	CASELOAD PER INVESTIGATOR/AUDITOR
Sacramento	50	12.5 to 1
Los Angeles	141	17.6 to 1
San Francisco	47	11.7 to 1
San Diego	96	19.2 to 1

If staffing had been in accordance with the proposal, the caseload for each working investigator/auditor would have been more manageable but still in excess of a desired ratio of 5 to 1.

REGION	PROPOSED STAFFING INVESTIGATOR/AUDITOR	CASELOAD PER WORKING INVESTIGATOR/AUDITOR
Sacramento	5	10.1 to 1
Los Angeles	15	9.4 to 1
San Francisco	5	9.4 to 1
San Diego	5	19.2 to 1

It has been determined that each working investigator/auditor can be expected to handle five cases. This decision was based on past and present experience and an analysis of the complexity of the pending cases. By January 1, 1979, there were 27 working investigators/auditors; the caseload had increased to 472. This is an average of 17.5 cases per working investigator/auditor. There were no vacant slots. It would appear reasonable to employ additional working investigators/auditors in order to effectively accomplish the Unit's mission.

2. Review of Three Regions

On-site reviews were conducted at three of the four regional offices of the Medi-Cal Fraud Unit. The purpose of the reviews was to compare and contrast methods and procedures established to investigate and prosecute cases of provider fraud. At each office the Supervising Attorney and the Supervising Investigator were interviewed. There is but slight variance in the way the supervisors envision their roles from region to region.

A sample of the pending workload was reviewed in each region. In all regions the cases were appropriate for investigation by a Unit certified under Section 17. Unfortunately, there is insufficient investigative staff to meet the rapidly increasing workload demands. Therefore, timeliness of investigations is not adequate. Unless additional investigative personnel can be hired, cases with good prosecutive potential may fall victim to the statute of limitations.

a. San Diego Region

The on-site review of San Diego was conducted on October 31 and November 1, 1978. The staff consisted of:

1 Supervising Attorney
1 Supervising Investigator
4 Investigators
1 Auditor

The Supervising Attorney was interviewed. He sees his role as a three-pronged one. He is an administrator; he is a trial attorney; and he is a legal resource person from whom the investigators can seek advice on evidentiary requirements, admissibility of evidence, grants of immunity, etc. He feels that his role as legal advisor to the staff is very important so that problems can be eliminated before they occur.

The Supervising Investigator sees himself as an administrator, also. He does not have a caseload of his own, but rather coordinates the work of the team. He provides training to inexperienced staff, serves as a resource person for investigative techniques, and provides guidance to the staff on investigative reports. It is the Supervising Investigator who prioritizes and assigns cases for investigation.

The Supervising Investigator reported that the pending workload had increased to 113, or 22.6 cases per working investigator/auditor, as of November 1. He estimated, and a review confirmed, that approximately one-half of the pending cases had excellent potential for prosecution.

The region had had one conviction. This involved the bookkeeper of a pharmacy. The bookkeeper, who pleaded guilty, is scheduled to meet with the prosecutor prior to being sentenced, at which time it is expected that she will provide information necessary to prosecute others. The case, initially investigated by the Department of Health Services' Investigation Section, was transferred to the Medi-Cal Fraud Unit when the Unit was formed.

It was anticipated that four cases would be filed before the end of 1978. In addition, seven more cases which are under active investigation should be filed by June of 1979.

Because of the heavy workload, the Supervising Investigator was experimenting with a workload management system. Under this system, each working investigator/auditor had been assigned five cases. Thus 25 of the cases with the highest priority were being actively investigated. The remainder of the workload was dormant.

Priority 2 cases are those which are scheduled to be assigned to each working investigator/auditor once his workload falls below five cases. In San Diego, 20 Priority 2 cases were reviewed on-site. Each case appeared to have excellent potential for successful prosecution.

Ten of the Priority 2 cases involve psychiatrists and psychologists who are billing the Medicaid program for various mental health services which have not been performed. The Unit recognizes that this practice not only harms title XIX financially, it also deprives the disturbed Medicaid patient of needed care. Additional investigators are badly needed to control these flagrant billings. Some of the suspects have Medicaid earnings in excess of $100,000 per year. Since the maximum allowance for one hour of psychotherapy is $32 in California, the most a person could earn if he worked 8 hours per day, 5 days per week, 52 weeks per year, in a practice of 100 percent Medi-Cal patients, would be $66,560 per year. Thus, this is a fertile area for finding fraudulent billings. The remaining Priority 2 cases involved a mix of physicians, suppliers, convalescent homes, etc.

Subsequent to our review, it became statewide policy to prioritize workload and to assign five cases to each working investigator/auditor.

b. San Francisco Region

The on-site review of the Medi-Cal Fraud Unit's San Francisco regional office was performed November 16 and 17, 1978. The Supervising Attorney reported that the staff consisted of:

1 Supervising Attorney
1 Supervising Investigator
3 Investigators
1 Auditor

One more investigator was scheduled to come on board on November 20. Temporarily, the region has the services of a volunteer attorney. The volunteer is a registered nurse and a recent law school graduate who is awaiting the results of her bar examination. She works two days per week doing legal research. At the time of our review the research centered around confidentiality of investigative files (e.g., Can the volunteer have access to the files?).

In addition to her duty to serve as the region's trial attorney, the Supervising Attorney envisions her role as that of an administrator who assumes responsibility for investigations at the time they are submitted to her for prosecution. She is always available to give advice on legal questions (search warrants, discovery, admissibility, etc.). She feels that the Supervising Investigator should supervise all pending investigations and provide his staff with training and guidance on investigative techniques.

All investigative reports are reviewed first by the Supervising Investigator and then by the Supervising Attorney. The format in use is the one formerly used by the Investigation Section. Because of certain legal problems which might arise as a result of the current format, the San Francisco region is preparing a report-writing manual to aid the investigators of the whole unit and to reduce the potential for prosecutive difficulties.

There were 52 cases pending in San Francisco on November 16, 1978. This averages at 13 cases per working investigator/auditor. Each case is assigned to an investigator or auditor. However, in reality, a person can concentrate on only two or three cases at a time. During "slow" periods investigators begin to prepare their pending cases for field work by ordering claims and printouts from the fiscal intermediary. The San Francisco staff feels that by having all cases assigned they will be able to reduce the length of time it takes to resolve an allegation once the case becomes "active." This is because delays are encountered between requesting and receiving documents from the fiscal intermediary. Using their system, all documents are in file when the investigator is ready to perform the field work. The statewide priority system which calls for each investigator to have a five-case workload was initiated subsequent to this review.

The main office of the fraud unit is encouraging district supervisors in the Investigation Section to refer cases to the Unit as soon as there is "reasonable cause to believe a crime has been committed. In making this judgment on borderline cases, district supervisors are urged to err in favor of referral rather than retain a case and unduly delay an investigation." Cases are being received with minimal documentation as a result of this policy. The region feels, considering its backlog, that such encouragement is not justified.

Of the 52 pending cases, 16 appear to have good prosecutive potential. Most cases involve psychiatric services. One case is pending with an AUSA in Sacramento; it involves FBI and DOD agents who are responsible for Medicare and CHAMPUS violations. There are two cases pending with district attorneys.

A review of 18 pending cases, selected at random, revealed that cases are being well documented and investigated in a professional manner. One is being "operated." However, some cases with already proven counts are languishing in the pending, due to staffing limitations.

c. Los Angeles Region

An on-site review of the Los Angeles regional office of the Medi-Cal Fraud Unit was performed December 6 and 7, 1978. Staffing consists of:

3 Attorneys
3 Supervisory Investigators
9 Investigators
1 Auditor

There were 167 cases pending on December 6, 1978, or 18.3 cases for each of the nine working investigators. The auditor has two cases assigned and assists all staff on cases which require accounting expertise. None of the supervisors has a caseload.

Since its inception, the Los Angeles region has filed criminal complaints against six suspects; one has been convicted. It is expected that there will be six more filings in the very near future.

Each attorney in the region is responsible for five cases. The attorney in charge anticipates that it will be necessary to hire one more attorney. He explained that each attorney can handle no more than five cases because of the complexity of the cases. In addition to having sole responsibility for any case which is to be filed, the attorneys are becoming involved in directing investigations at an early stage, in training activities, and in writing research memoranda for statewide use.

When a case is received in the region, it is screened by the lead Supervisory Investigator. If the case meets the criteria for investigation by the Unit, it is opened and a docket number is assigned. The case is then prioritized by another Supervisory Investigator.

Each working investigator has five assigned cases. Assigned cases are Priority 1. Priority 2 cases are those which are scheduled to be assigned as workload permits and which have the highest probability of resulting in prosecution; there are 26 cases classified as Priority 2. The remaining cases are in Priorities 3, 4, and 5. (There are now only four priority classes.)

The need for additional staff is critical. In 20 of the Priority 2 cases there is already evidence to prove at least one count per case, and, as the Priority 2 cases age awaiting investigation, the statute of limitations is running out. More importantly, fraudulent practices continue unchecked.

3. Staffing

The application for funding of a Medicaid fraud-control unit filed by the Office of the Attorney General stated that the regional offices would be staffed with experienced investigators. "The investigators and auditors will be assigned to investigation-audit teams, each to consist of four senior investigators and one auditor." Each region was to have one experienced Supervising Investigator who would be in charge of the teams. In San Diego, the smallest region, the Supervising Investigator was to be a working supervisor. In Los Angeles, the largest region, the senior investigator on each team was to serve as a "Lead Investigator" who would supervise the work of the team and work cases himself.

The Unit has not followed the proposal. In San Diego, the Supervising Investigator has no workload. In Los Angeles, there are three Supervising Investigators, none of whom has a workload.

The Unit's intention to use investigative supervisors as active investigators did not prove to be practical or realistic. It was not expected that cases would be assigned to teams or groups of investigators. However, there are occasions when more than one investigator must be used for a particular function. This includes taking statements from witnesses, executing search warrants, etc. The alternatives are to pull an investigator from another case to assist or to use the Supervising Investigator as the second man in these situations.

The Unit has opted to use the Supervising Investigator as the assistant. This results in having one of the most experienced investigative personnel on the scene during the more sensitive phases of each investigation. By using the supervisor as a "second man," the less experienced investigator benefits from the supervisor's knowledge and experience. In addition, the supervisor is permitted to observe the investigator and to evaluate performance.

We knew that the investigators hired initially would not all be "Senior Special Investigators." This was because of the transfer policy between the Department of Health's Investigation section and the Medi-Cal Fraud Unit. However, one newly hired investigator in San Diego is classified as an "Investigative Assistant." This is a position below that of a trainee. The person filling this position has no investigative experience and no medical background. We recommend that, when new investigator positions are filled, that they be filled with experienced investigators in accordance with the application for funding.

4. Public Complaints or Allegations

The Medi-Cal Fraud Unit rarely receives complaints or allegations directly from the public. Disposition of such correspondence depends on the identity of the complainant.

If a recipient makes an allegation to the central office or to a regional office, the allegation is referred to the Department of Health's Investigation Section for preliminary screening. However, allegations from "insiders," such as providers, or employees of providers, are generally kept by the Unit; these informants are considered to be a very reliable source of information.

5. Suggestions From Investigators

Several investigators voiced the opinion that their job could be better performed if they were POST-certified. POST certification would guarantee a well-trained staff. Others feel that they should be allowed to carry weapons for self-protection. They were designated peace officers by the Attorney General under Section 830.3 of the Penal Code, but the authority to carry weapons was specifically withheld. The investigators related several instances of being in dangerous interview situations with recipients who had felony "rap sheets" in which a weapon could have served as protection. Centrally, the Unit is gathering data to determine the economic feasibility of obtaining POST certification.

Another suggestion was that the State should enter into provider agreements which would give the Unit access to medical records. The Unit supports this concept.

Currently it is illegal for a person not entitled to Medi-Cal to use a Medi-Cal card. Several investigators stated that there should be an exception to this restriction for law enforcement purposes. This, too, is being supported by the Unit centrally.

6. Recommendations

1. The Medi-Cal Fraud Unit should hire additional experienced working investigators.
2. The Unit should provide a rationale for assigning five cases to each working investigator/auditor.

VI. Disposition of Cases

Outcome of investigations where evidence of abuse or fraud is established fall into two categories:

- Administrative Actions
- Criminal Prosecutions

A. Administrative Actions

Administrative actions occur when there is a violation of regulations for which some disciplinary measure may be taken. Actions include:

- Verbal Warning or Instructions
- Warning Letter
- Referrals to Recovery
- Suspension

Administrative action may be taken in advance of or concurrently with criminal prosecution. Where both administrative action and criminal action are contemplated, the case is cleared between the Medi-Cal Fraud Unit and the Department of Health Services.

Upon determination that there is sufficient evidence to justify suspension of a provider from the Medi-Cal program, with or without recovery, the Medi-Cal Fraud Unit presents the case to the Department of Health Services for review. If there is concurrence, the case is transmitted to the Civil Division of the Attorney General's office.

Upon receipt of the case, the Civil Law Section of the Attorney General's office prepares and serves an accusation. The case is then presented to an Administrative Hearing Officer of the Office of Administrative Hearings.

The office is composed of a group of civil service hearing officers who are attorneys sitting as quasi-judicial officers in all State administration matters. A hearing officer reviews the evidence submitted by the Attorney General's office at public hearings to determine whether the evidence supports the allegations of violation of State law or regulation.

If he finds that it does, he recommends termination or suspension of the privileges of the provider under the Medi-Cal program. Hearing officers make findngs of fact only. Only the Director of the Department of Health has the power to suspend a provider based on findings of the hearing officer. A provider suspended for a limited term is automatically reinstated upon completion of the ordered period of suspension. A terminated provider may petition for reinstatement after one year has elapsed. If he is denied reinstatement another hearing must be held and an order of denial or reinstatement adopted by the Director. A list of suspended and ineligible providers is published quarterly by the Investigation Section. There were 157 providers on the ineligible list in July of 1978.

B. Criminal Prosecution

Criminal actions occur when there are violations of statutes that constitute a felony or misdemeanor.

1) Statutes for Prosecution

There are numerous State statutes under which prosecution of cases can be brought in State courts. The principle criminal statutes used are:

1. Section 14107 of the Welfare and Institutions Code, and
2. Section 72 of the Penal Code.

Section 14107 of the Welfare and Institutions Code is a specific statute which prohibits a person from knowingly and intentionally filing a false Medicaid claim. Violation is punishable by up to one year in the county jail, or up to five years in state prison, or by a fine up to five thousand dollars, or by both fine and imprisonment.

Section 72 of the Penal Code is a more general statute which prohibits the intentional filing of false claims against State boards and agencies. Violation is punishable by up to one year in the county jail and/or a fine of up to one thousand dollars, or by imprisonment in the State prison for up to five years and/or a fine not exceeding ten thousands dollars.

Each of the above cited statutes is an alternative felony/misdemeanor under California law. This means that when the Judge sentences the already convicted provider, his sentence determines whether the crime was a felony or a misdemeanor.

The statute of limitations for each statute is three years. The statute begins on the date the claim is submitted on the first cited statute. For the second, it begins on the date of discovery of the fraudulent act.

Prosecution can also be undertaken for other Medi-Cal specific statutes (notification of use of and charges by reference laboratory) or under more general statutes such as grand theft, petty theft, conspiracy, etc.

2) Authority to Handle Prosecution

Prior to the certification of the Medi-Cal Fraud Unit, prosecution of Medi-Cal fraud cases was handled by local district attorneys. This is still occurring to some extent in a few counties. The following section will discuss the continuing prosecution by some district attorneys. During 1978, thirteen (13) convictions were obtained by local district attorneys. These convictions resulted from investigations conducted by the Department of Health Services. (Exhibit 11).

3) Relationship with District Attorneys

Medi-Cal Fraud Unit personnel visited each District Attorney and offered to prosecute all Medi-Cal cases. The offer was accepted by most counties. Some counties requested that they be allowed to review cases prior to their being filed by the Unit. However, the Unit's offer was resisted in six counties covered by the San Francisco region. The counties of Alameda, Lake, Monterey, and San Francisco will not allow the Attorney General to prosecute the Medi-Cal casess. Contra Costa and Solano counties have not yet made a final decision.

California's proposal to receive 90% funding for a Section 17 Unit stated in part that the Attorney General would investigate and prosecute all cases of Medi-Cal fraud. The Department of Health, Education, and Welfare was assured, prior to its certification action, that the Unit would be prosecuting virtually all cases of Medi-Cal fraud. We agreed that those cases already in the hands of local prosecutors should remain where they were. In addition, the Department was assured that the District Attorneys would cooperate with the Unit's attempts to prosecute.

The first paragraph on page 5A of the Unit's application for funding was added to the package on May 12, 1978, as a result of our concerns that the Unit, to be certified under 42 CFR 450.310(d)(1), would have to have authority to prosecute all violations. The Director of the Medi-Cal Fraud Unit provided the following rationale for establishing such a relationship with some district attorneys:

> "The California Constitution vests the Attorney General with the authority to prosecute violations of law in any county, and the Medi-Cal Fraud Unit cannot 'relinquish' that constitutionally mandated prosecutive authority.
>
> "The agreement submitted with out grant application provided that the Attorney General would 'promptly prosecute or assist local prosecutors in the prosecution of all cases meriting prosecution, as provided by law' (see Grant Application, page 8). In accordance with the longstanding cooperative relationship between the California Attorney General and the district attorneys of California counties, the Supervising Deputy Attorney General of each Region met with district attorneys of the counties in the Region. In six counties the unit agreed to permit the district attorneys to prosecute Medi-Cal Fraud cases, after investigation by the Medi-Cal Fraud Unit and determination by the Supervising Deputy Attorney General of the region that the case should be filed criminally. If the district attorney does not desire to prosecute the case criminally, we will do so. It was made clear that the judgment whether a case is criminal or not will be made by the Supervising Deputy Attorney General of the Medi-Cal Fraud region.

> "The practical effect of this arrangement is that we obtain 'free' prosecutorial assistance. While such an arrangement is not very satisfactory to the attorneys in the unit (who, of course, would prefer to prosecute their own cases), the effect on the program from the federal standpoint should prove beneficial. If, however, this procedure results in inadequate prosecutorial investment of time and effort in Medi-Cal provider fraud cases, we will reconsider these arrangements."

4) Convictions

The Medi-Cal Fraud Unit had obtained five convictions during the first six months of operations. Three of these were filed during the Unit's existence while the other two had been filed under the auspices of the Investigation Section of the Department of Health Services. There are additional ten cases which have been filed but which have not been resolved. Six of these were filed by the Unit; the other four had been filed by the Investigation Section prior to July 1, 1978. Exhibit 12 reflects statistics on filings and convictions as of December 31, 1978.

The San Francisco regional office of the Medi-Cal Fraud Unit has submitted a request to the United States Department of Justice to designate the Supervising Attorney a Special Assistant United States Attorney. This would permit prosecution of appropriate Title XIX cases in Federal court and would permit the Unit to include Medicare and CHAMPUS counts in their indictments.

VII. Restitution and Recovery

A. Administrative

Once an overpayment has been established by the Investigation Section, or SURS, or the Medi-Cal Fraud Unit, and it has been decided that the overpayment should be recovered, the Investigation Section or SURS prepares a demand letter and sends it to the provider or recipient. A courtesy copy is sent to the Recovery Section, which is then responsible for the actual collection of the overpayment. Once the Recovery Section takes the case, the Investigation Section or SURS closes its case.

The Medi-Cal Fraud Unit has established a policy for insuring the recovery of overpayments in unprosecutable cases. If the overpayment was established by a valid audit trail, and is in excess of $5,000, the overpayment is referred to the Health Recovery Unit for collection and the case is returned to the Investigation Section. The Medi-Cal Fraud Unit tracks the recovery efforts. If the overpayment is less than $5,000, both the case and the computations are referred to the Investigation Section for whatever action they deem appropriate.

Within the Recovery Section, it is the responsibility of the Compliance Unit to collect overpayments from recipients and providers. The Compliance Unit can negotiate a repayment schedule. If a provider or recipient makes periodic payments based on a repayment schedule, seven percent interest is charged. Before a repayment agreement is negotiated, the Compliance Unit requires income tax returns and cash flow information from the overpaid party.

In addition to imposing interest penalities, Recovery Section can pursue an overpayment in small claims court if the amount is $750.00 or less. For larger amounts, the Recovery Section can present a case to the Attorney General's Office. There are no specific instructions for when to discontinue collection efforts. The decision is made by the tax representative and his or her supervisor. If a provider files an appeal, the Recovery Section receives a copy of the acknowledgement letter from the Appeals Board. Recovery Section will stop all collection activity and close the case. If the appeal is denied in whole or in part, the Recovery Section will resume collection activities. Interest is computed from the date of the demand letter.

The statute of limitations for recovery is generally three years from the date of payment. If fraud is involved, the three years begins on the date of discovery of the overpayment.

The chief of the Recovery Section indicated that collection efforts could be improved if there were federal statutes defining debts. There are presently no federal statutes which define a debt. Moreover, there are no HEW guidelines regarding debt collection.

Medi-Cal Intermediary Operations (MIO) also recovers overpayments. Usually recovery is accomplished through future claim adjustments or institutional cost report settlement. Medi-Cal Intermediary Operations cannot negotiate repayment schedules. This is done by the Recovery Section. The Recovery Section provides guidelines to MIO on collection activities.

Generally, recovery of an overpayment by MIO must be effected immediately (within twelve months in a negotiated settlement). If, after 90 days, the rate of recovery is less than 7% per month, MIO must turn over its receivable account to the Recovery Section.

B. Civil

The Investigation Section of Audits and Investigations may seek a civil recovery of an overpayment at the same time that a criminal action is pending. All civil actions are handled by the Office of the Attorney General. The criminal complaint is handled by Medi-Cal Fraud Control Unit or by a district attorney. Typically, a conference between the investigator/auditor and the provider is held prior to the release of any demand letter.

During the fiscal year ending June 30, 1978, the Recovery Section collected $11,612,463 from all sources.

There were 2,040 investigation cases representing a total of $2,837,399.10 (accounts receivable). $387,974.30 had been collected. There were 54 SURS cases representing a total value of $644,877.96 (accounts receivable). $95,850.44 had been collected.

As of November 30, 1978, there were 2,102 investigation cases representing $2,820,765.61 in accounts receivable. $225,017.53 had been collected since July 1, 1978. There were 75 SURS cases representing $1,188,864.94 in accounts receivable. $58,653.84 had been collected since July 1, 1978.

VIII. Factoring

The Code of Federal Regulations Section 447.10 which implements Section 1902(a)(32) of the Social Security Act prohibits State payments to anyone other than a provider or recipient, except in specified circumstances. Subsection (h) specifically prohibits payment to a factor, ("an individual or an organization, such as a collection agency or service bureau, that advances money to a provider for accounts receivable that the provider has assigned, sold or transferred to the individual organization for an added fee or as a deduction of a portion of the accounts receivable"), either directly or by power of attorney.

California's definition of factoring does not differ from the Federal definition. However, the Department of Health Services has not issued any formal instructions regarding the prohibition against reassignment of provider claims to Medi-Cal providers. According to the State officials interviewed, State regulations clearly prohibit the practice. Section 14115.5 of the Welfare and Institutions Code was cited as a basic State law prohibiting such practices. This Section provides that "no transfer or assignment, at law or in equity, of any right of a provider of health care to any payment shall be enforceable against the State, a fiscal intermediary or carrier". Additionally, subsection (b) of Section 51501 of the California Administrative Code was cited as another mechanism prohibiting factoring. This subsection restricts payments for services to eligible providers listed in Section 51051 of the California Administrative Code who meet the standards for participation.

Despite formal procedures prohibiting reassignment of claims, the fiscal intermediary has not developed procedures to detect such a practice. Procedures have not been developed by the State agency for communication to the fiscal intermediary for implementation. MIO has questioned the State agency on the propriety of mailing a provider's checks to places other than a business address or bank. The State obtained a legal opinion on this issue which stated that a provider's checks could be mailed anywhere the provider requested as long as the check was made out in the name of the provider.

To date, State agency investigators have not uncovered any evidence of factoring.

Recommendation:

The State agency should develop procedures, to be implemented by its new fiscal intermediary, to detect the existence of factoring among Medi-Cal providers.

IX. Internal Security

A. Employee Conflict of Interest (DHS)

In order to prevent fraud or abuse on the part of State employees, the Department of Health Services adheres to the Department's Conflict of Interest Code. These regulations are contained in the California Administrative Code, Title 22, Division 2, Section 20100ff. The code is intended to provide reasonable assurance that foreseeable conflict of interest situations will be disclosed and prevented thus ensuring that the interests of the public are protected.

As an additional safeguard to assure the integrity of State employees, the Department issued a memorandum dated December 15, 1976, entitled "Incompatible Activity Statement". (Exhibit 13.)

B. Security (DHS - Investigations)

Procedures for maintaining security of pending and closed files are contained in the Investigation Manual, Section 512 (Exhibit 14). Basically, district offices as well as headquarters have desks and roll-around file cabinets which are locked to assure security. Investigators' pending cases are kept in locked tubs. In the Los Angeles office, there is a separate locked room for evidence. Only the investigative staff members have access to fraud and abuse files. Custodial staff have keys to work areas after normal work hours, but they do not have keys to file cabinets.

C. Mail Room (DHS - Investigation)

Personnel in the mail room do not open mail directed to the Investigation Section. Correspondence sent from the Investigation Section to other sources is sealed by the Investigation Section and sent to the mail room for postage only.

D. Medi-Cal Fraud Unit

Security in the Medi-Cal Fraud Unit appears to be more than adequate. The regional offices maintain investigative files and evidence in extremely secure conditions. Admittance to the offices is restricted. Visitors must register with a receptionist and must be accompanied by a Unit employee at all times.

Investigative files are kept in locked storage cabinets. Evidence is stored in locked evidence rooms. Access to files and evidence is restricted to personnel with a demonstrable need to know.

E. Security Control - Check Writing

The State agency does not itself issue checks. All checks are issued by the fiscal intermediary. Checks are stored under special security at the fiscal intermediary. Only certain employees at the MIO are allowed into the check-write area. This activity is audited by Audits and Investigations at MIO.

All returned checks go to the plan of which the provider is a member. There, an employee determines why the check was returned, and makes a disposition on it by returning it to the Programs Accounting Department for re-deposit.

A check will be reissued if a provider returns a check because of overpayment. The warrant is rewritten in the correct amount. Checks are also reissued to reflect a change of address. However, according to State officials, very few checks are reissued for this reason. Approximately 200,000 checks are issued each month.

The State will assume check writing responsibility when its new fiscal intermediary, Computer Science Corporation, becomes operational.

X. Reporting

Each of the entities involved in fraud and abuse control maintains various internal reports, and provides certain reports to the Office of Program Integrity on its activities.

A. Internal Reports

1) SURS

SURS maintains several reporting forms to assist management in evaluating the SURS activity.

When an investigation is finished, a review report is completed summarizing the important points of the case. Essential information normally available from this report includes:

Provider identification and type of practice or speciality

Date of the review

Source of the referral or complaint

Nature of the complaint or allegation

Review team members

Annual Medi-Cal payments and, if known, the percent of Medi-Cal business

Case findings and recommended corrective actions

This report allows management to evaluate the results of field investigations and provides a record of individual case development.

An On-Site Review Schedule is provided to SURS headquarters by the field offices. This report lists reviews scheduled for a two week period. It serves as a management tool in controlling workload and staffing priorities.

2) Investigation Section

A Monthly Activity Report is compiled by headquarters. This report is a summary of monthly activity reports submitted by the district field offices, and is compiled from each office's complaint log and investigator tallies. Exhibit 9 is the annual summary of the Monthly Activity Reports.

3) Medi-Cal Fraud Unit

The Medi-Cal Fraud Unit's Analyst is responsible for filing necessary reports and for maintaining workload records. The following describes the reports and statistics prepared and maintained by the Analyst:

a) Docket Cards

Docket cards form the basis for preparing forms HCFA-50 and HCFA-54. A card is completed in the region when a case is opened and a docket number is assigned. A duplicate of the card is sent to Sacramento. When updated information is posted to the region's card, a photocopy is sent to Sacramento so that their card can be updated. The docket cards contain a wealth of information about the suspect, the alleged violations, and the status of the investigation and court actions.

b) Inventory of Cases by Sources

The Analyst prepares a monthly and quarterly report which summarizes the source of each newly opened case. There are eighteen sources listed. The information is reported separately for each region.

c) Inventory of Cases by Type

Another report, prepared monthly and quarterly, analyzes the type of suspect involved in newly opened cases. The report shows the number of cases opened in each region which involve the category of sole practitioner, institution, laboratory, and supplier.

d) Monthly Case Status and Caseload Tallies

The Anaylst prepares this report which compares the regions in the areas of numbers of investigations, court cases, and administrative actions. The report also compares the caseloads of the attorneys, auditors, and investigators in each regions.

e) Job Codes by Hour and Class

This report is prepared monthly; the information is summarized quarterly. Using the weekly time reports filed by each attorney, auditor, and investigator, the Analyst shows the time spent by each class of employee in twenty-four (24) activities such as travel, training, leave, interviewing, examing records, writing reports, preparing for trail, prosecution, etc. (The weekly time reports are also being used to determine the number of hours expended by each class of employee on each specific case.)

In addition to preparing reports the Analyst is responsible for tracking the collection of overpayments which have been referred to the Recovery Section of the Department of Health Services.

B. External Reports

The implementation of the Medicare/Medicaid workload reporting system on July 1, 1978, required State Fraud Units and Medicaid State agencies to complete a form HCFA-50 (Medicare/Medicaid Fraud Report) and HCFA-51 (Medicare/Medicaid Abuse Report) for each full-scale investigation. The forms, summarizing information about each case, are to be submitted to the Regional Office of Program Integrity. As the status of the case changes, updated reports are to be submitted. In addition to these individual reports, quarterly summary reports are also required.

SURS and the Investigation Section are submitting the individual and summary reports as required. The Medi-Cal Fraud Unit discontinued submitting HCFA-50's to the Office of Program Integrity because of its concerns about safeguarding personal information from improper disclosure to third parties. A similar position has been taken by other Fraud Units around the country. Resolution of this issue is pending in HEW-Central. Quarterly summary reports are being submitted by the Medi-Cal Fraud Unit as required.

EXHIBIT	TITLE
10 -	Office of Health Investigations - Yearly Activity Report: Statewide
11 -	Health Investigation Section - Significant Activity 1978
12 -	Medi-Cal Fraud Unit - 7/1/78 - 12/31/78 - Significant Activity
13 -	Department of Health - Incompatible Activity Statement
14 -	Case Files - Security Maintenance - Health Services

FRAUD AND ABUSE CONTROL

LIST OF EXHIBITS

EXHIBIT — TITLE

1 - Organization Chart - California Department of Health Services

1A - Department of Health Services - Division/Branch Organization

1B - Medi-Cal Division Organization

1C - Medi-Cal Operations Branch

1D - Health Recovery Section

2 - Investigation Section

3 - Surveillance and Utilization Review Section

3A - Proposed 1979-80 SURS Organization

3B - SURS Organization positions allocated as of 10/16/78

4 - Office of the Attorney General - Organization Chart

4A - Medi-Cal Fraud Unit - Organization as Certified 7/1/78

4B - Medi-Cal Fraud Unit - Organization as of 12/78

5 - Procedure and critieria for referral of cases

6 - Chart - primary responsibility for fraud and abuse control

7 - MIO Flow Chart - Identification of suspicion of abuse

8 - MIO referrals

9 - SURS Quarterly Activity Report - total

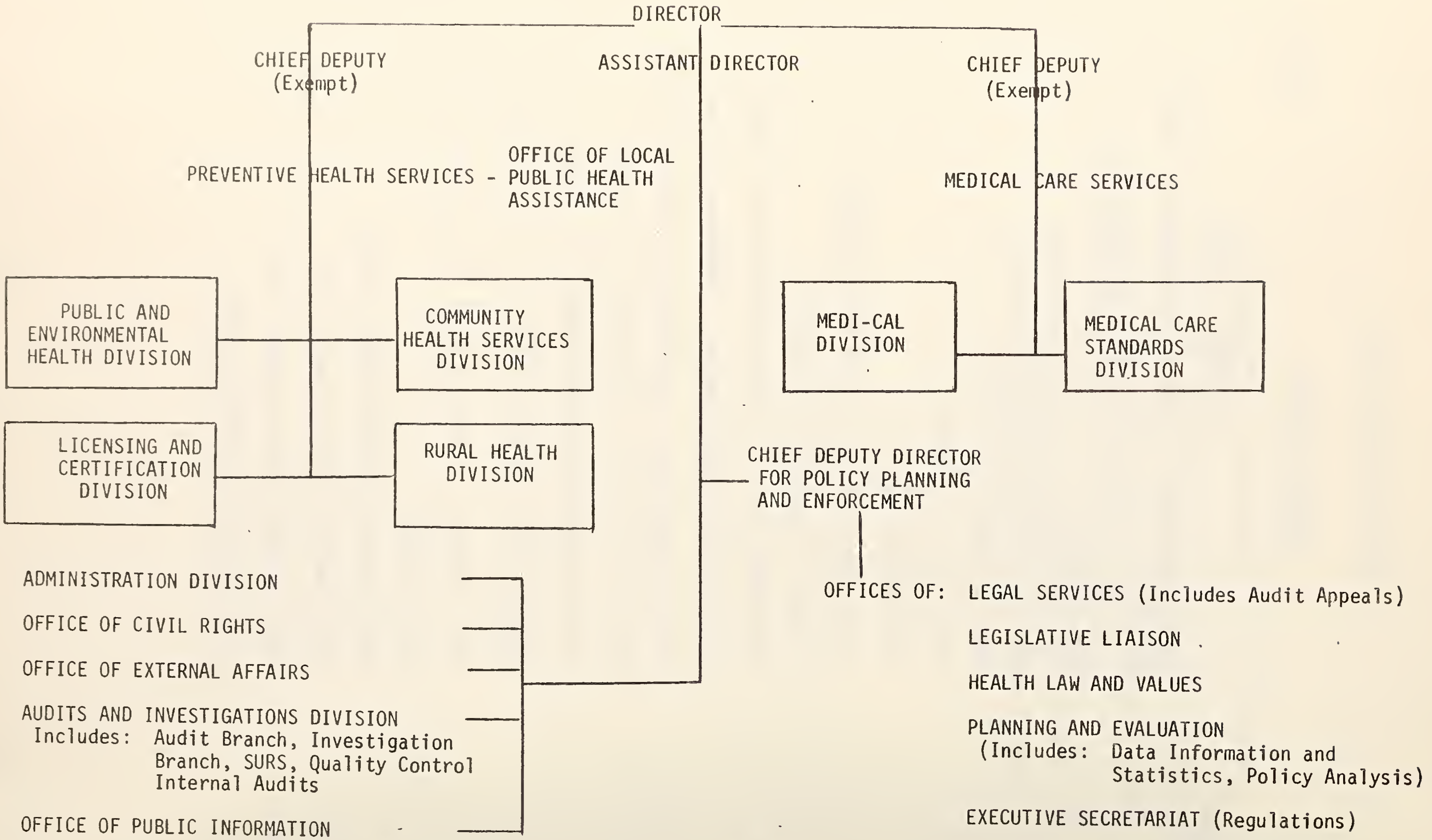
9A - SURS Quarterly Activity Report - LA

9B - SURS Quarterly Activity Report - SF

9C - Cost Avoidance from SPEAR Action

Exhibit 1

CALIFORNIA DEPARTMENT OF HEALTH SERVICES


DIRECTOR
CHIEF DEPUTY (Exempt)
ASSISTANT DIRECTOR
CHIEF DEPUTY (Exempt)
PREVENTIVE HEALTH SERVICES - OFFICE OF LOCAL PUBLIC HEALTH ASSISTANCE
MEDICAL CARE SERVICES
PUBLIC AND ENVIRONMENTAL HEALTH DIVISION
COMMUNITY HEALTH SERVICES DIVISION
MEDI-CAL DIVISION
MEDICAL CARE STANDARDS DIVISION
LICENSING AND CERTIFICATION DIVISION
RURAL HEALTH DIVISION
CHIEF DEPUTY DIRECTOR FOR POLICY PLANNING AND ENFORCEMENT
ADMINISTRATION DIVISION
OFFICE OF CIVIL RIGHTS
OFFICE OF EXTERNAL AFFAIRS
AUDITS AND INVESTIGATIONS DIVISION
Includes: Audit Branch, Investigation Branch, SURS, Quality Control Internal Audits
OFFICE OF PUBLIC INFORMATION
OFFICES OF: LEGAL SERVICES (Includes Audit Appeals)
LEGISLATIVE LIAISON
HEALTH LAW AND VALUES
PLANNING AND EVALUATION
(Includes: Data Information and Statistics, Policy Analysis)
EXECUTIVE SECRETARIAT (Regulations)

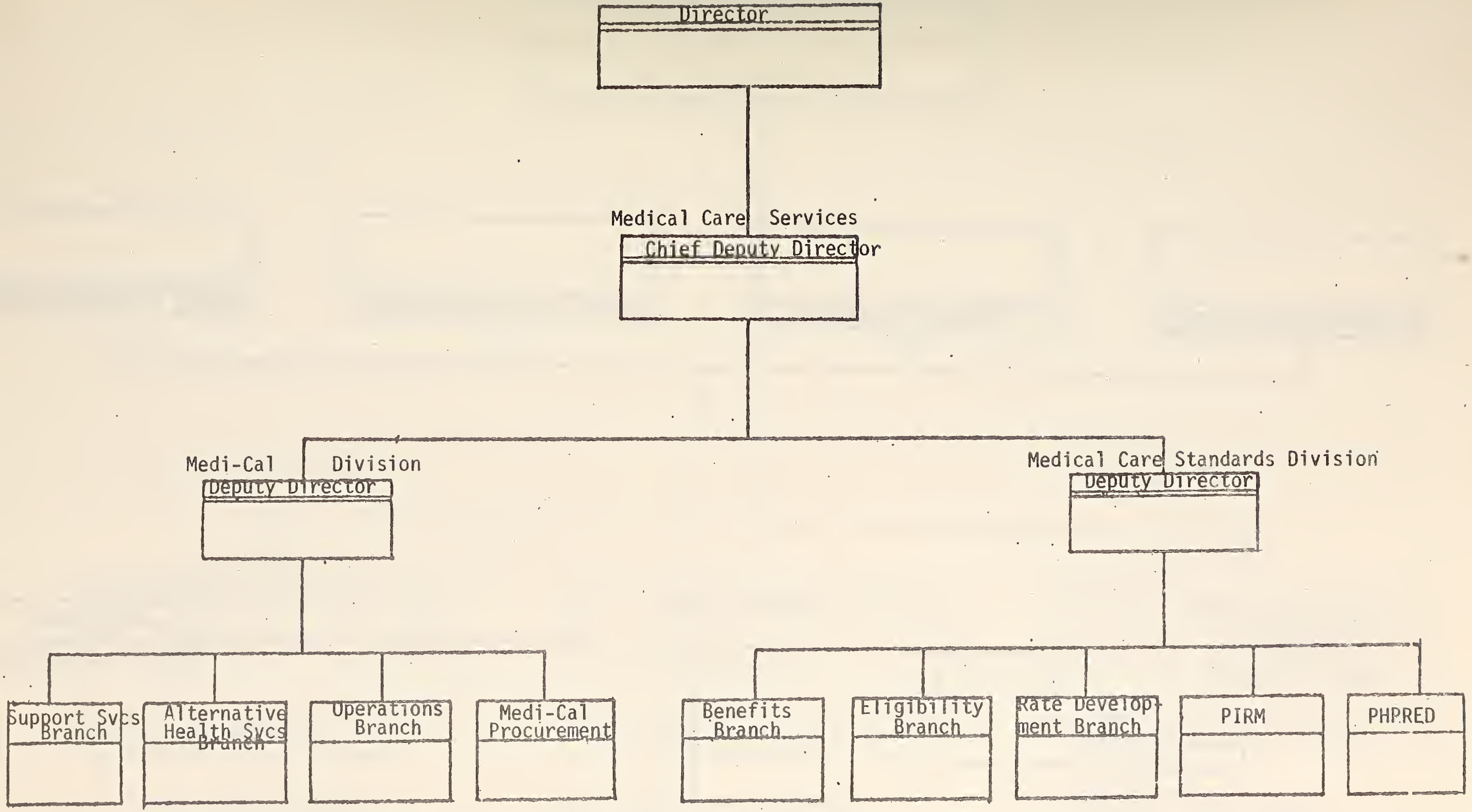

Director
Medical Care Services
Chief Deputy Director
Medi-Cal Division
Deputy Director
Medical Care Standards Division
Deputy Director
Support Svcs Branch
Alternative Health Svcs Branch
Operations Branch
Medi-Cal Procurement
Benefits Branch
Eligibility Branch
Rate Development Branch
PIRM
PHPRED

Exhibit 1B

CALIFORNIA DEPARTMENT OF HEALTH

Medi-Cal Division

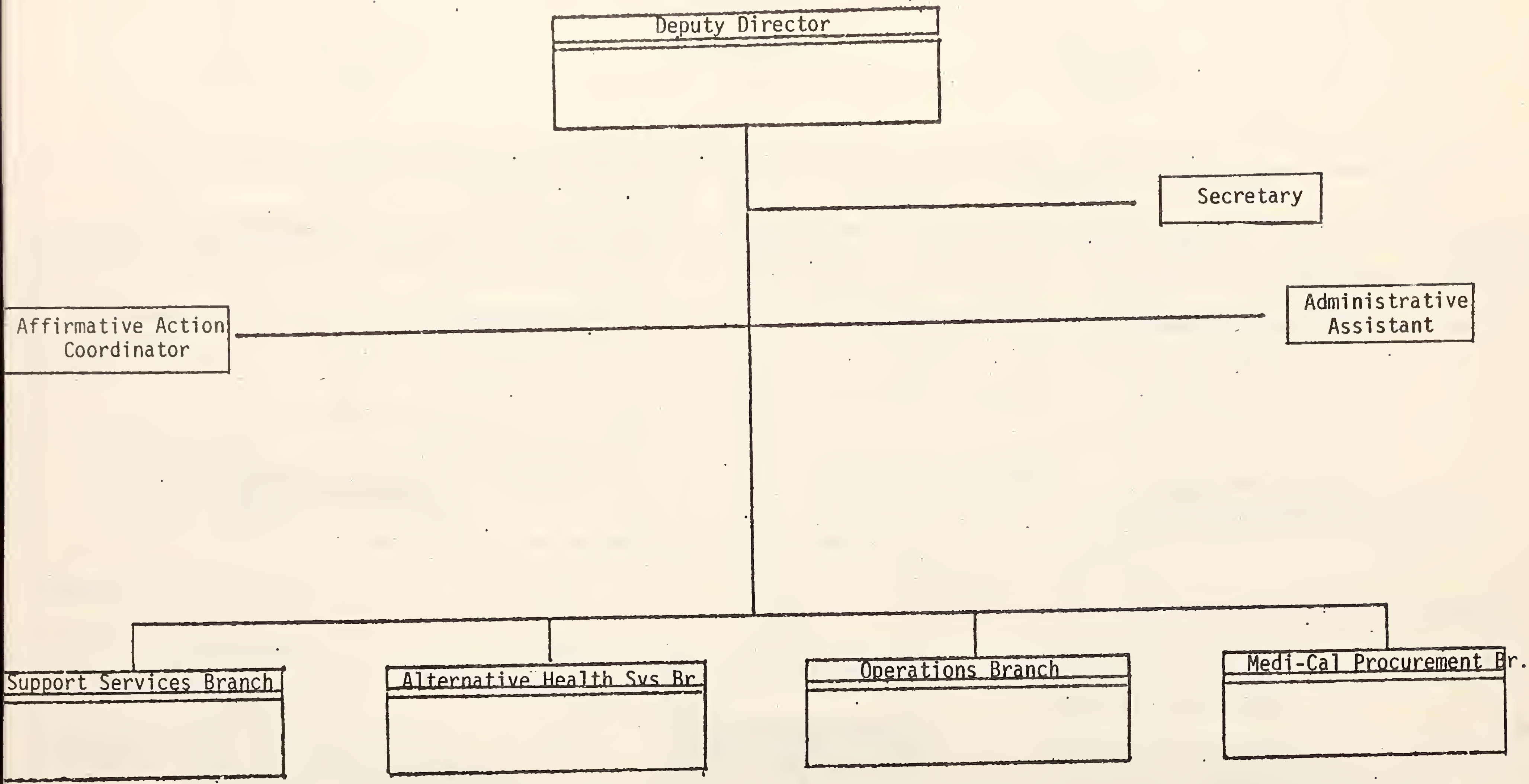
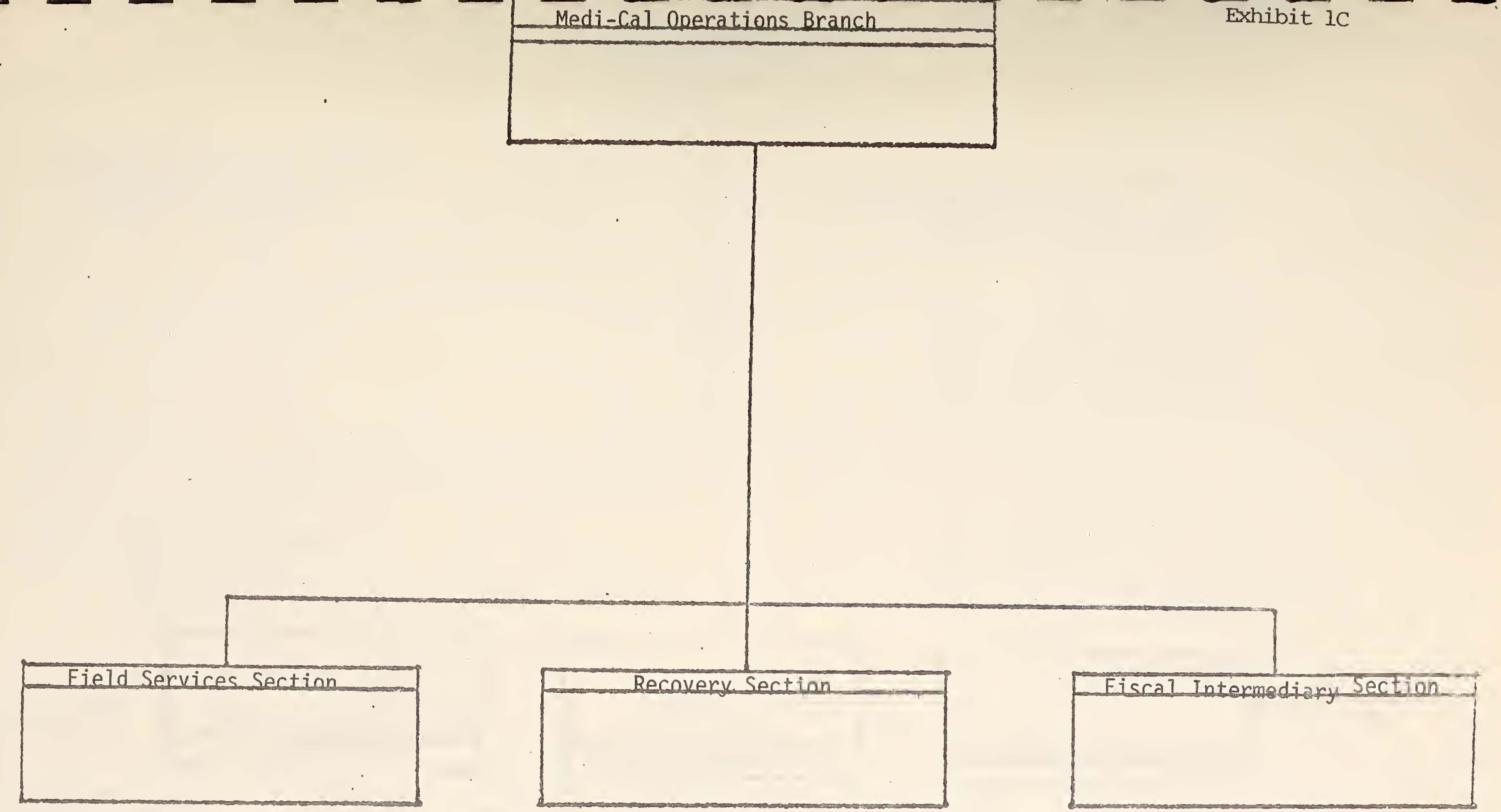

Deputy Director
Secretary
Affirmative Action Coordinator
Administrative Assistant
Support Services Branch
Alternative Health Svs Br.
Operations Branch
Medi-Cal Procurement Br.

Exhibit 1C


Medi-Cal Operations Branch
Field Services Section
Recovery Section
Fiscal Intermediary Section

- Overall responsibility for utilization control through:
  - a) Field office treatment authorization request (TAR) approval
  - b) PSRO program coordination/ monitoring
  - c) Quarterly SNF/ICF reviews Section 1903 (g)

- Responsible for recovery from third-party liabilities
- Recovery of overpayments from providers & recipients

- Monitoring of fiscal intermediary contract
- Contract administration
- Communication with providers via FI contract.

Exhibit 1D

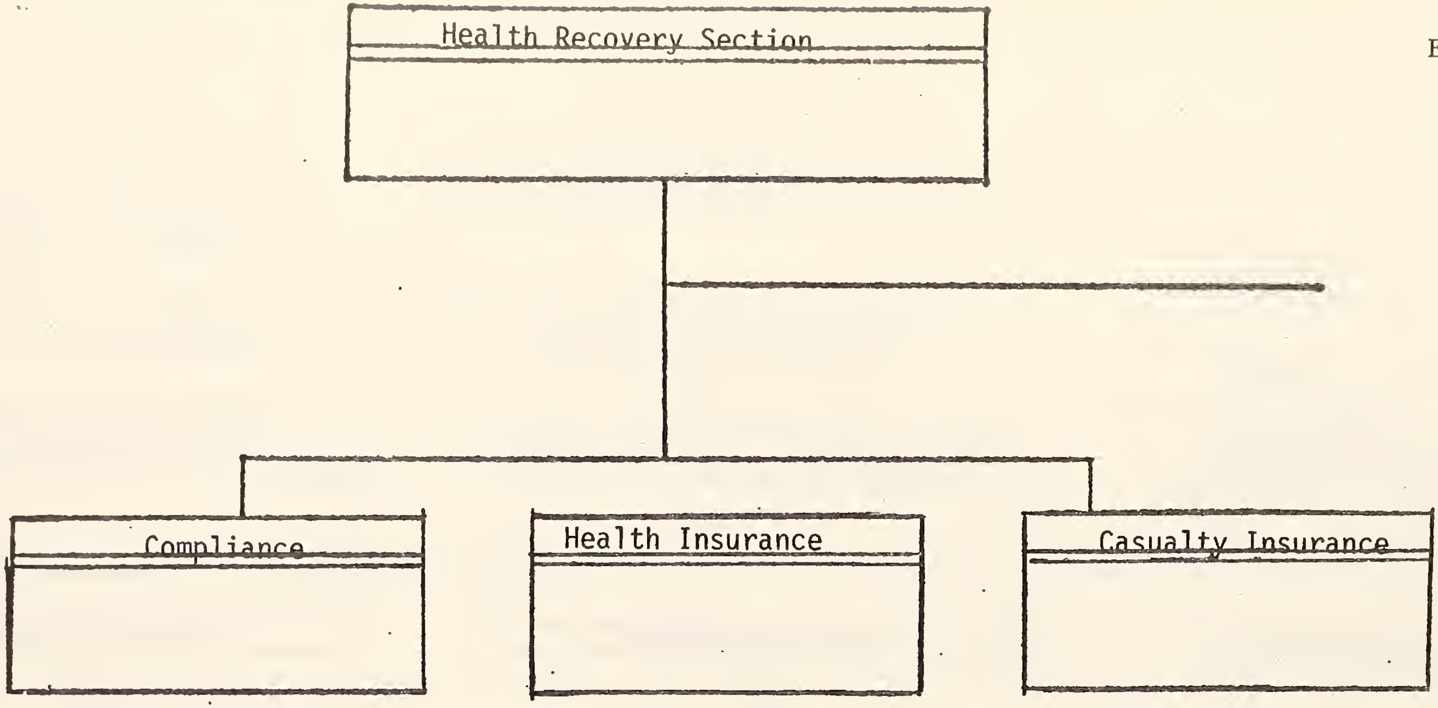

Health Recovery Section
Compliance
Health Insurance
Casualty Insurance

Exhibit 2

DEPARTMENT OF HEALTH SERVICES

INVESTIGATION SECTION

July 1, 1978

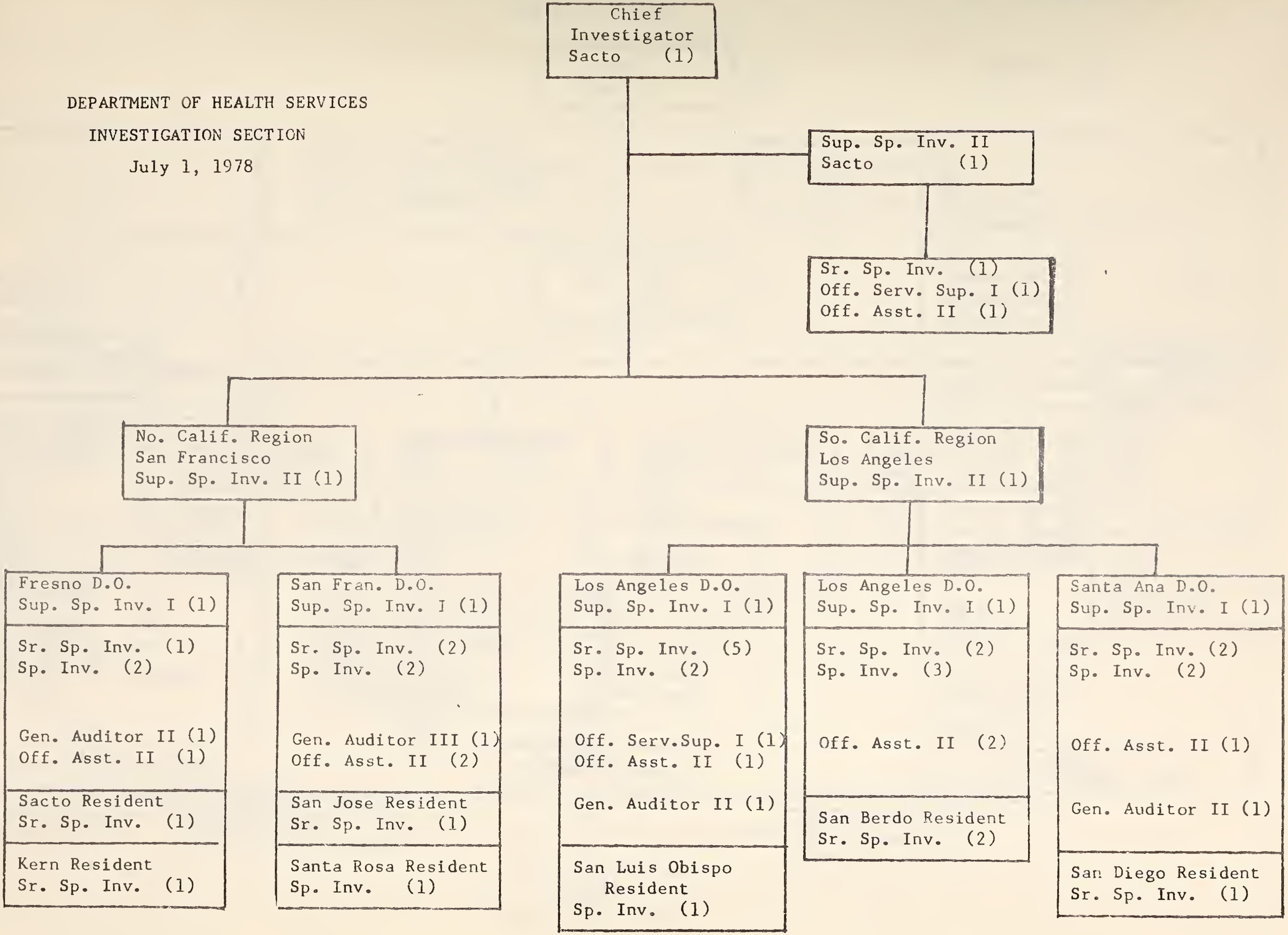
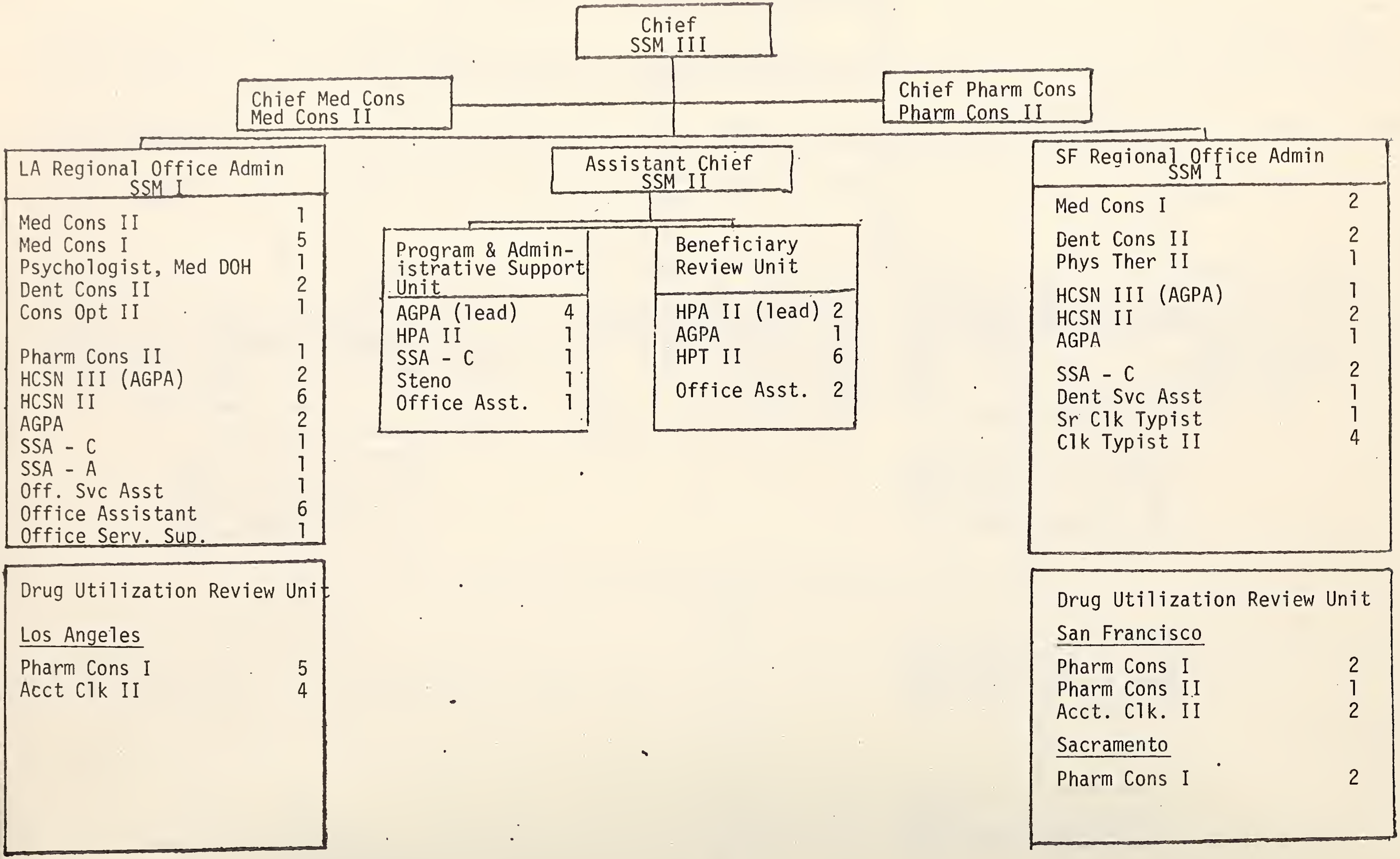

Chief
Investigator
Sacto (1)
Sup. Sp. Inv. II
Sacto (1)
Sr. Sp. Inv. (1)
Off. Serv. Sup. I (1)
Off. Asst. II (1)
No. Calif. Region
San Francisco
Sup. Sp. Inv. II (1)
So. Calif. Region
Los Angeles
Sup. Sp. Inv. II (1)
Fresno D.O.
Sup. Sp. Inv. I (1)
Sr. Sp. Inv. (1)
Sp. Inv. (2)
Gen. Auditor II (1)
Off. Asst. II (1)
Sacto Resident
Sr. Sp. Inv. (1)
Kern Resident
Sr. Sp. Inv. (1)
San Fran. D.O.
Sup. Sp. Inv. I (1)
Sr. Sp. Inv. (2)
Sp. Inv. (2)
Gen. Auditor III (1)
Off. Asst. II (2)
San Jose Resident
Sr. Sp. Inv. (1)
Santa Rosa Resident
Sp. Inv. (1)
Los Angeles D.O.
Sup. Sp. Inv. I (1)
Sr. Sp. Inv. (5)
Sp. Inv. (2)
Off. Serv.Sup. I (1)
Off. Asst. II (1)
Gen. Auditor II (1)
San Luis Obispo
Resident
Sp. Inv. (1)
Los Angeles D.O.
Sup. Sp. Inv. I (1)
Sr. Sp. Inv. (2)
Sp. Inv. (3)
Off. Asst. II (2)
San Berdo Resident
Sr. Sp. Inv. (2)
Santa Ana D.O.
Sup. Sp. Inv. I (1)
Sr. Sp. Inv. (2)
Sp. Inv. (2)
Off. Asst. II (1)
Gen. Auditor II (1)
San Diego Resident
Sr. Sp. Inv. (1)

Exhibit 3

SURVEILLANCE AND UTILIZATION REVIEW SECTION



Chief
SSM III

Chief Med Cons
Med Cons II

Chief Pharm Cons
Pharm Cons II

Assistant Chief
SSM II

LA Regional Office Admin
SSM I

Med Cons II	1
Med Cons I	5
Psychologist, Med DOH	1
Dent Cons II	2
Cons Opt II	1
Pharm Cons II	1
HCSN III (AGPA)	2
HCSN II	6
AGPA	2
SSA - C	1
SSA - A	1
Off. Svc Asst	1
Office Assistant	6
Office Serv. Sup.	1

Program & Administrative Support Unit

AGPA (lead)	4
HPA II	1
SSA - C	1
Steno	1
Office Asst.	1

Beneficiary Review Unit

HPA II (lead)	2
AGPA	1
HPT II	6
Office Asst.	2

SF Regional Office Admin
SSM I

Med Cons I	2
Dent Cons II	2
Phys Ther II	1
HCSN III (AGPA)	1
HCSN II	2
AGPA	1
SSA - C	2
Dent Svc Asst	1
Sr Clk Typist	1
Clk Typist II	4

Drug Utilization Review Unit

Los Angeles

Pharm Cons I	5
Acct Clk II	4

Drug Utilization Review Unit

San Francisco

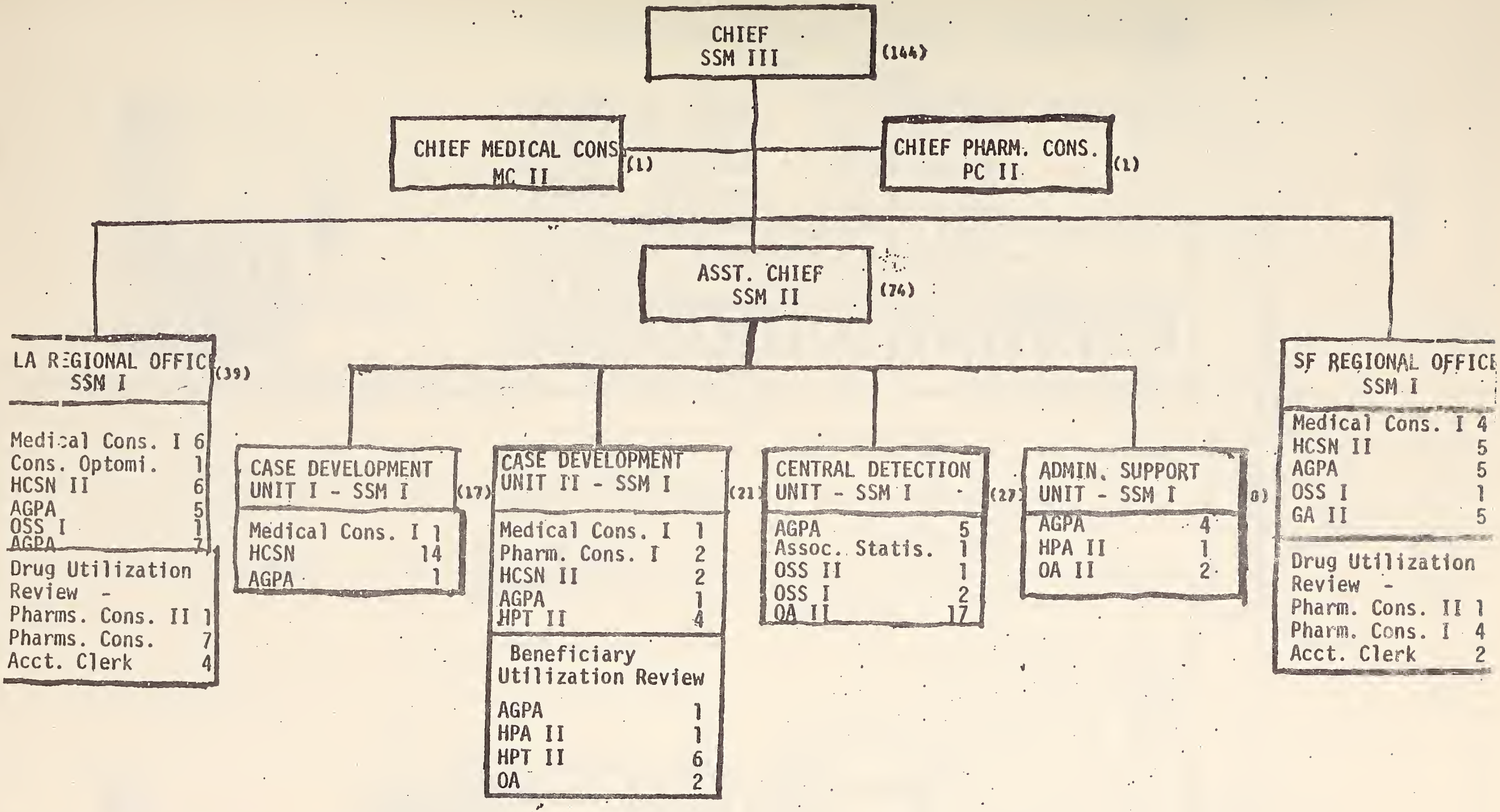
Pharm Cons I	2
Pharm Cons II	1
Acct. Clk. II	2

Sacramento

Pharm Cons I	2

June 6, 1978

Proposed 1979-80


CHIEF
SSM III
(144)
CHIEF MEDICAL CONS.
MC II
(1)
CHIEF PHARM. CONS.
PC II
(1)
ASST. CHIEF
SSM II
(74)
LA REGIONAL OFFIC
SSM I
(39)
Medical Cons. I 6
Cons. Optomi. 1
HCSN II 6
AGPA 5
OSS I 1
AGPA 7
Drug Utilization Review -
Pharms. Cons. II 1
Pharms. Cons. 7
Acct. Clerk 4
CASE DEVELOPMENT UNIT I - SSM I
(17)
Medical Cons. I 1
HCSN 14
AGPA 1
CASE DEVELOPMENT UNIT II - SSM I
(21)
Medical Cons. I 1
Pharm. Cons. I 2
HCSN II 2
AGPA 1
HPT II 4
Beneficiary Utilization Review
AGPA 1
HPA II 1
HPT II 6
OA 2
CENTRAL DETECTION UNIT - SSM I
(27)
AGPA 5
Assoc. Statis. 1
OSS II 1
OSS I 2
OA II 17
ADMIN. SUPPORT UNIT - SSM I
(8)
AGPA 4
HPA II 1
OA II 2
SF REGIONAL OFFIC
SSM I
Medical Cons. I 4
HCSN II 5
AGPA 5
OSS I 1
GA II 5
Drug Utilization Review -
Pharm. Cons. II 1
Pharm. Cons. I 4
Acct. Clerk 2

Audits and Investigation Division
Surveillance and Utilization Review Section
August 30, 1978

SURVEILLANCE AND UTILIZATION REVIEW

October 16, 1978

Exhibit 3B

Chief

SSM III - P. Keller

Asst Chief

SSM I J. R. Ruiz

(31)
Med Con I
Med Con I
Med Con I
Med Con I*
Med Con I
Med Con I
Psychologist (Medical)
Dental Con II*
Dental Con II
Con Opto II
Health Care Sv Nurse III
Health Care Sv Nurse III*
Health Care Sv Nurse II
Health Care Sv Nurse II
Health Care Sv Nurse II
Health Care Sv Nurse II*
Health Care Sv Nurse II*
Health Care Sv Nurse II
Health Care Sv Nurse II
AGPA
SSA-C*
SSA-C
Dental Asst*
Off Asst I/II(Typing)*
Off Asst I/II(Typing)*
Off Asst I/II(Typing)*
Off Asst I/II(Typing)*
Off Asst I/II(Typing)
Off Asst I/II(Typing)
Off Sv Supv I(Typing)

DURU (9)

Pharm Con II
Pharm Con I
Pharm Con I
Pharm Con I
Pharm Con I
Pharm Con I
Acct Clk/Off Asst (Gen)
Acct Clk/Off Asst (Gen)
Acct Clk/Off Asst

SSM I J. Kelly

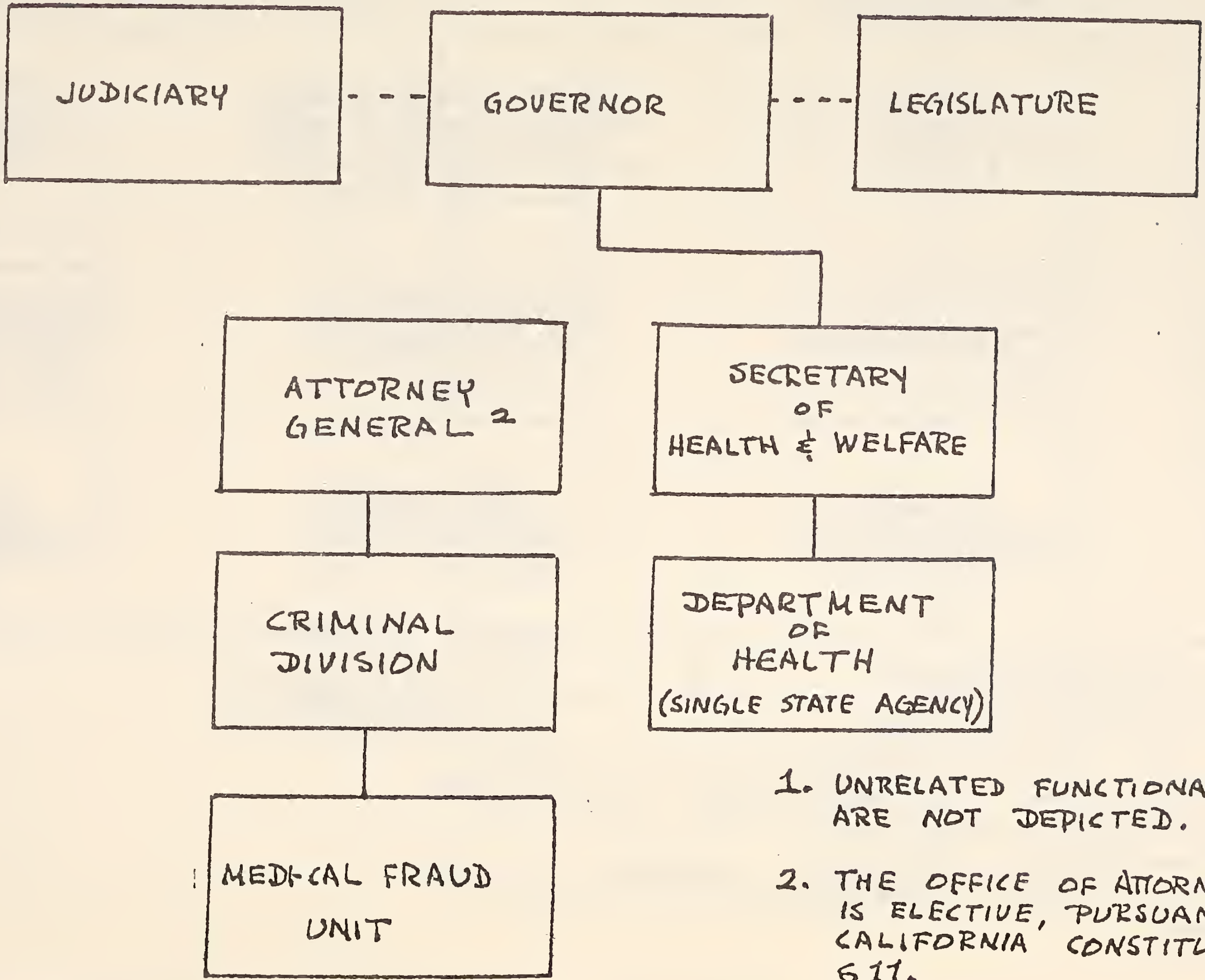
(25)
Med Con I
Med Con I
Med Con I*
Med Con I
Health Care Sv Nurse II
Health Care Sv Nurse II
Health Care Sv Nurse II
Health Care Sv Nurse II
Health Care Sv Nurse II
Health Care Sv Nurse II
Health Care Sv Nurse II*
Dental Con II
Dental Con II*
Dental Asst*
Assoc Gov Prog Analyst
Assoc Gov Prog Analyst
Assoc Gov Prog Analyst*
Staff Sv Analyst-C
Physical Therapy Con
Off Sv Sup I
Off Asst I/II(Typing)
Off Asst I/II(Typing)*
Off Asst I/II(Typing)*
Off Asst I/II(Typing)*

DURU (7)

Pharm Con II
Pharm Con I
Pharm Con I
Pharm Con I
Pharm Con I
Acct Clk/Off Asst(Gen)
Acct Clk/Off Asst(Gen)

Exhibit 4

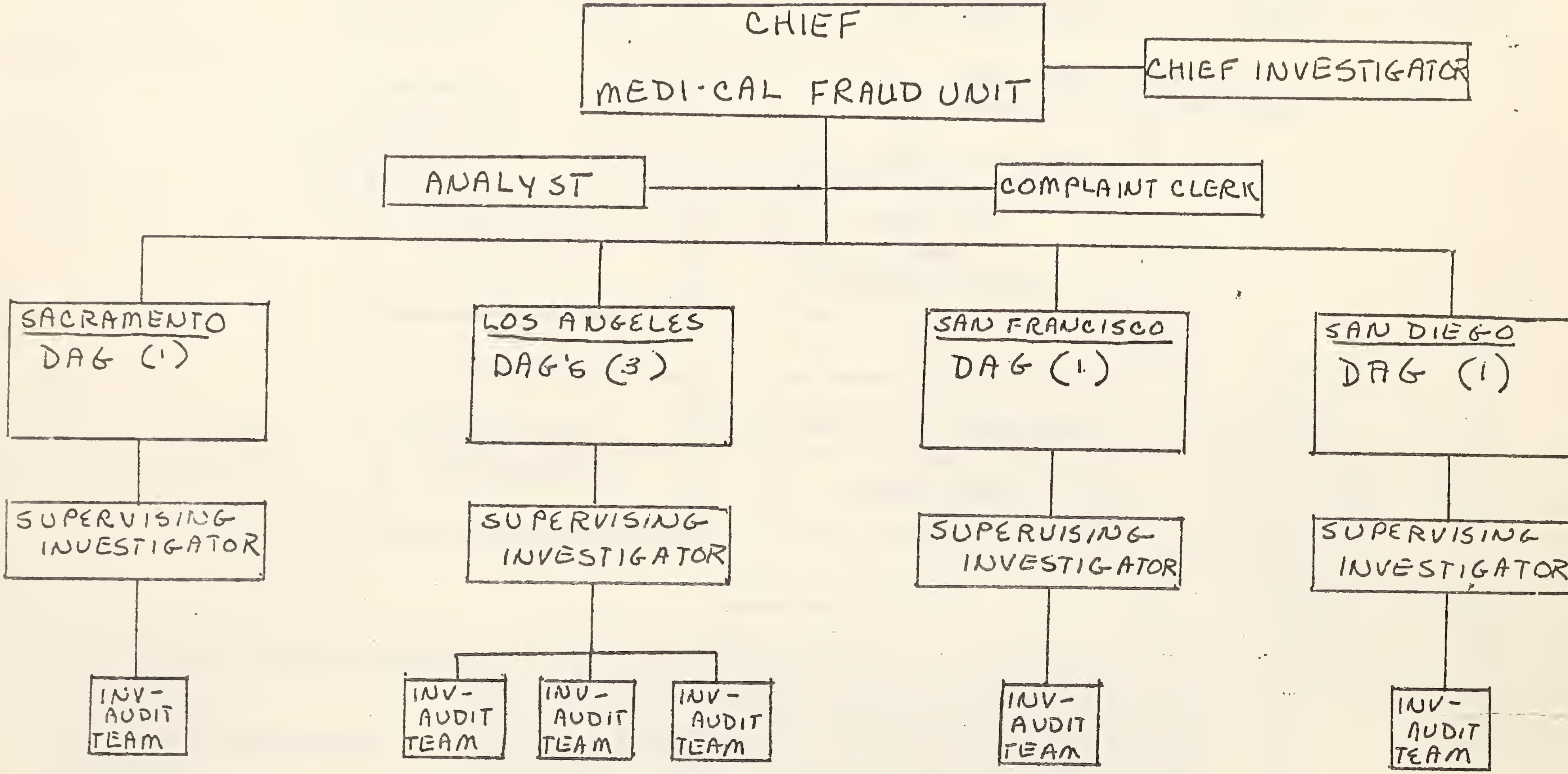
LOCATION WITHIN STATE GOVERNMENT OF THE OFFICE OF THE ATTORNEY GENERAL[1]


JUDICIARY
GOVERNOR
LEGISLATURE
ATTORNEY GENERAL [2]
SECRETARY OF HEALTH & WELFARE
CRIMINAL DIVISION
DEPARTMENT OF HEALTH (SINGLE STATE AGENCY)
MEDICAL FRAUD UNIT

1. UNRELATED FUNCTIONAL UNITS ARE NOT DEPICTED.

2. THE OFFICE OF ATTORNEY GENERAL IS ELECTIVE, PURSUANT TO THE CALIFORNIA CONSTITUTION, ART. V, § 11.

Exhibit 4A

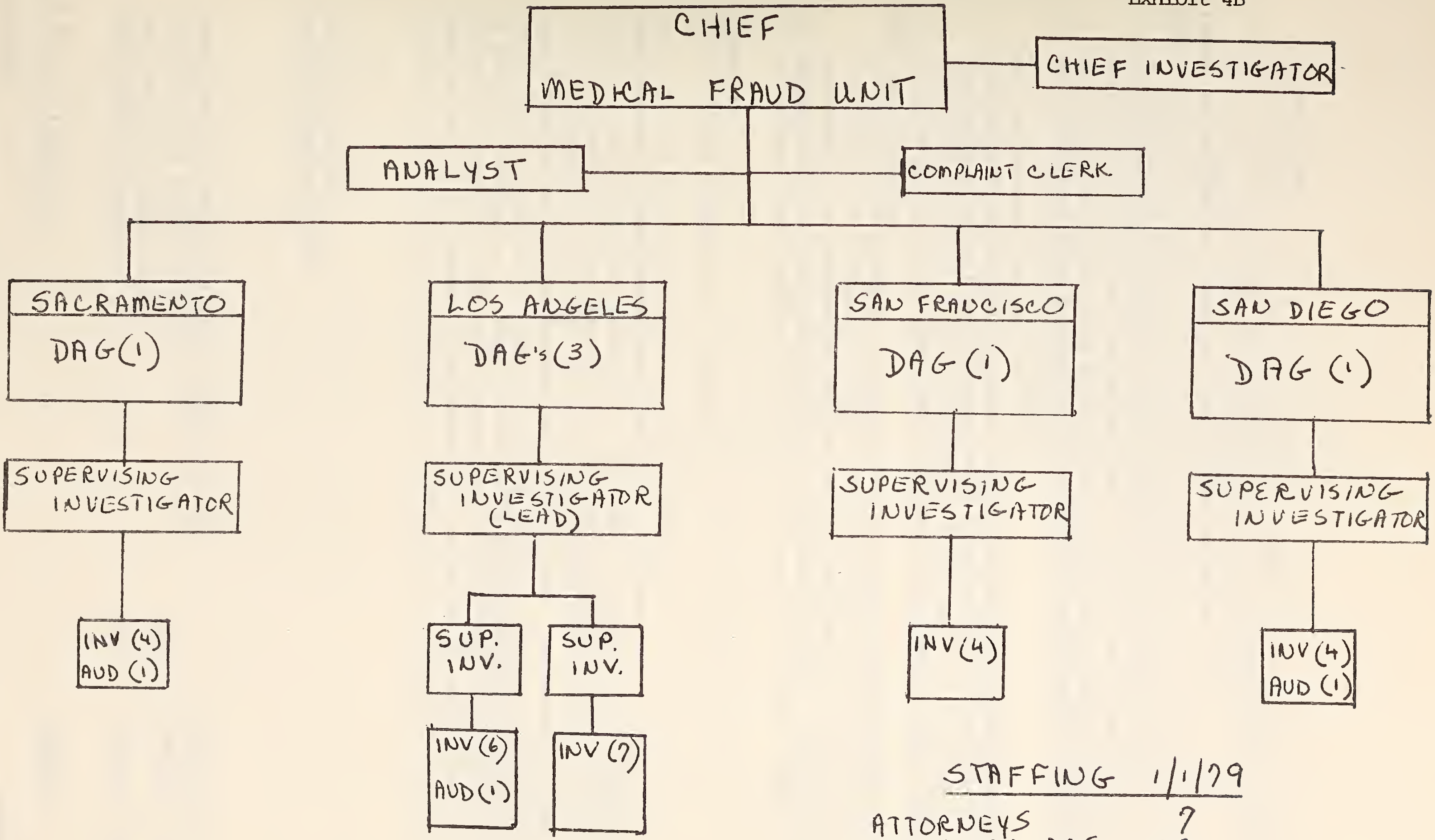

CHIEF
MEDI-CAL FRAUD UNIT
CHIEF INVESTIGATOR
ANALYST
COMPLAINT CLERK
SACRAMENTO
DAG (1)
LOS ANGELES
DAG'S (3)
SAN FRANCISCO
DAG (1)
SAN DIEGO
DAG (1)
SUPERVISING INVESTIGATOR
SUPERVISING INVESTIGATOR
SUPERVISING INVESTIGATOR
SUPERVISING INVESTIGATOR
INV-AUDIT TEAM
INV-AUDIT TEAM
INV-AUDIT TEAM
INV-AUDIT TEAM
INV-AUDIT TEAM
INV-AUDIT TEAM

INVESTIGATION-AUDIT TEAM	
SR. INVESTIGATORS	(4)
AUDITORS	1

STAFFING

ATTORNEYS	7
INVESTIGATORS	29
AUDITORS	6
ANALYSTS	1
COMPLAINT CLERKS	1
CLERICAL SUPPORT	15
	59

Exhibit 4B


CHIEF
MEDICAL FRAUD UNIT
CHIEF INVESTIGATOR
ANALYST
COMPLAINT CLERK
SACRAMENTO
DAG (1)
LOS ANGELES
DAG's (3)
SAN FRANCISCO
DAG (1)
SAN DIEGO
DAG (1)
SUPERVISING INVESTIGATOR
SUPERVISING INVESTIGATOR (LEAD)
SUPERVISING INVESTIGATOR
SUPERVISING INVESTIGATOR
INV (4)
AUD (1)
SUP. INV.
SUP. INV.
INV (6)
AUD (1)
INV (7)
INV (4)
INV (4)
AUD (1)

STAFFING 1/1/79

ATTORNEYS	7
INVESTIGATORS	32
AUDITORS	3
ANALYST	1
COMPLAINT CLERK	1
CLERICAL SUPPORT	10
	57

State of California Department of Health

Memorandum

Exhibit 5

To : Department of Justice
Medi-Cal Fraud Units (MCFU)

Department of Health Services
Investigation Section District Offices (DHS)

Date : July 31, 1978

Subject : Procedure and Criteria for Referral of Cases

From : Marjory Winston Parker
Gerald B. Rohlfes

Because of the increasing complaint workload and the staffing cuts that have been made to DHS, it is necessary to abbreviate the criteria and procedures for the referral of cases to assure the expeditious investigation and prosecution of fraud by Medi-Cal providers. Please disregard previous instructions on this subject, and effective immediately, DHS district supervisors should refer all provider cases, preliminary investigations and complaints to the appropriate MCFU as soon as the information developed in the investigation or contained in the complaint is sufficient to provide the DHS district supervisor with reasonable cause to beleive a crime has been committed. In making this judgment on borderline type cases, district supervisors are urged to err in favor of referral rather than to retain a case and unduly delay an investigation.

The following examples are presented to illustrate the interpretation of this criteria:

1. On a Beneficiary Explanation of Medi-Cal Benefit Statement (BEOMBS), which a beneficiary has indicated that he/she did not receive a reported service, the case should be referred to MCFU as soon as DHS obtains a claim copy or other information to verify the accuracy of the information reported on the BEOMBS. It will not be necessary for DHS to contact the beneficiary nor the provider.

2. On a complaint originating from the fiscal intermediary, SURS, DURU, a licensing agency or a law enforcement agency, which is received with some developed evidence, the case should be referred to MCFU immediately, upon determining the probability of a criminal violation having occurred. It will not be necessary to prove a count.

3. On a complaint from a beneficiary or a welfare department, alleging that a provider took two or more medi labels for a service, the case should be referred to MCFU as soon as DHS obtains a printout verifying that the provider billed for more than the services which the beneficiary asserts he received.

The procedure and format for the referral of these cases, preliminary investigations and complaints from DHS to MCFU shall be as follows:

1. Upon determination of the foregoing criteria, the DHS district supervisors will prepare a mini memo (Standard Form 100B) as shown on the attached illustration.

2. The DHS district supervisor should pull a copy of the mini memo and file it in alphabetic order by name of the subject.

3. The DHS district supervisor should attach, to the mini memo, all available information related to the case and trasmit it to MCFU.

4. The MCFU should promptly, upon completion of their investigation, return a copy of the mini memo, with a copy of their investigation report, indicating the outcome of their investigation.

5. The DHS district should file the returned mini memo in their alpha file to indicate the status and outcome of the referral.

If you have any questions with this criteria or procedure, please discuss this with your supervisor.

Attachment

Gerald B Rohlfs

Marjorie Parker

CALIFORNIA
MEMO
-R (REV. 9-70)

TO:
Tony Wright
Supv. Spec. Investigator
Department of Justice
Medi-Cal Fraud Unit
350 McAllister St. Rm. 6000
San Francisco, CA 94102

CONFIDENTIAL

SUBJECT: Shady Acres
Convalescent Hospital
Novato, CA
No case #

DATE 8-1-78

The attached information pertaining to subject Medi-Cal provider is referred to your office for criminal investigation. Upon completion of your investigation, please return a copy of this memo with a copy of your investigation report.

RN TO	SIGNED ► Howard Norris	ADDRESS 100 Mission St., Room 801, San Francisco	PHONE 597-2330

Sample

	ADDRESS	DATE

SEND PARTS 1 AND 3 INTACT — PART 3 WILL BE RETURNED WITH REPLY

Exhibit 6

PRIMARY RESPONSIBILITY FOR FRAUD AND ABUSE CONTROL

Activity	Audits and Investigations		Fiscal Intermediary Section	Fiscal Intermediary	Recovery Section	Attorney General
	SUR	Investigation				
Determine fraud and abuse surveillance policies	X		X			X
Write manuals for fraud and abuse surveillance		X	X	X		X
Decide to refer cases to law enforcement officials		X[1]				X
Decide to investigate cases		X		X		X
Perform desk audit	X	X		X		X
Perform field audit	X	X				X
Perform collection of third party claims					X	
Perform utilization review	X			X		
Conduct surveillance of:						
- inpatient hospitals	X			X		
- skilled nursing facilities	X			X		
- intermediate care facilities	X			X		
- physicians	X			X		
- dentists	X			X		
- chiropractors	X			X		
- podiatrists	X			X		
- optometrists	X			X		
- outpatient hospitals	X			X		
- clinics	X			X		
- laboratory and radiology facilities	X			X		
- home health	X			X		
- drugs	X			X		

PRIMARY RESPONSIBILITY FOR FRAUD AND ABUSE CONTROL

Activity	Audits and Investigations		Fiscal Intermediary Section	Fiscal Intermediary	Recovery Sections	Attorney General
	SUR	Investigation				
Determine fraud and abuse surveillance policies	X		X			X
Write manuals for fraud and abuse surveillance		X	X	X		X
Decide to refer cases to law enforcement officials		X[1]				X
Decide to investigate cases		X		X		X
Perform desk audit	X	X		X		X
Perform field audit	X	X				X
Perform collection of third party claims					X	
Perform utilization review	X			X		
Conduct surveillance of:						
- inpatient hospitals	X			X		
- skilled nursing facilities	X			X		
- intermediate care facilities	X			X		
- physicians	X			X		
- dentists	X			X		
- chiropractors	X			X		
- podiatrists	X			X		
- optometrists	X			X		
- outpatient hospitals	X			X		
- clinics	X			X		
- Laboratory and radiology						

Exhibit 7

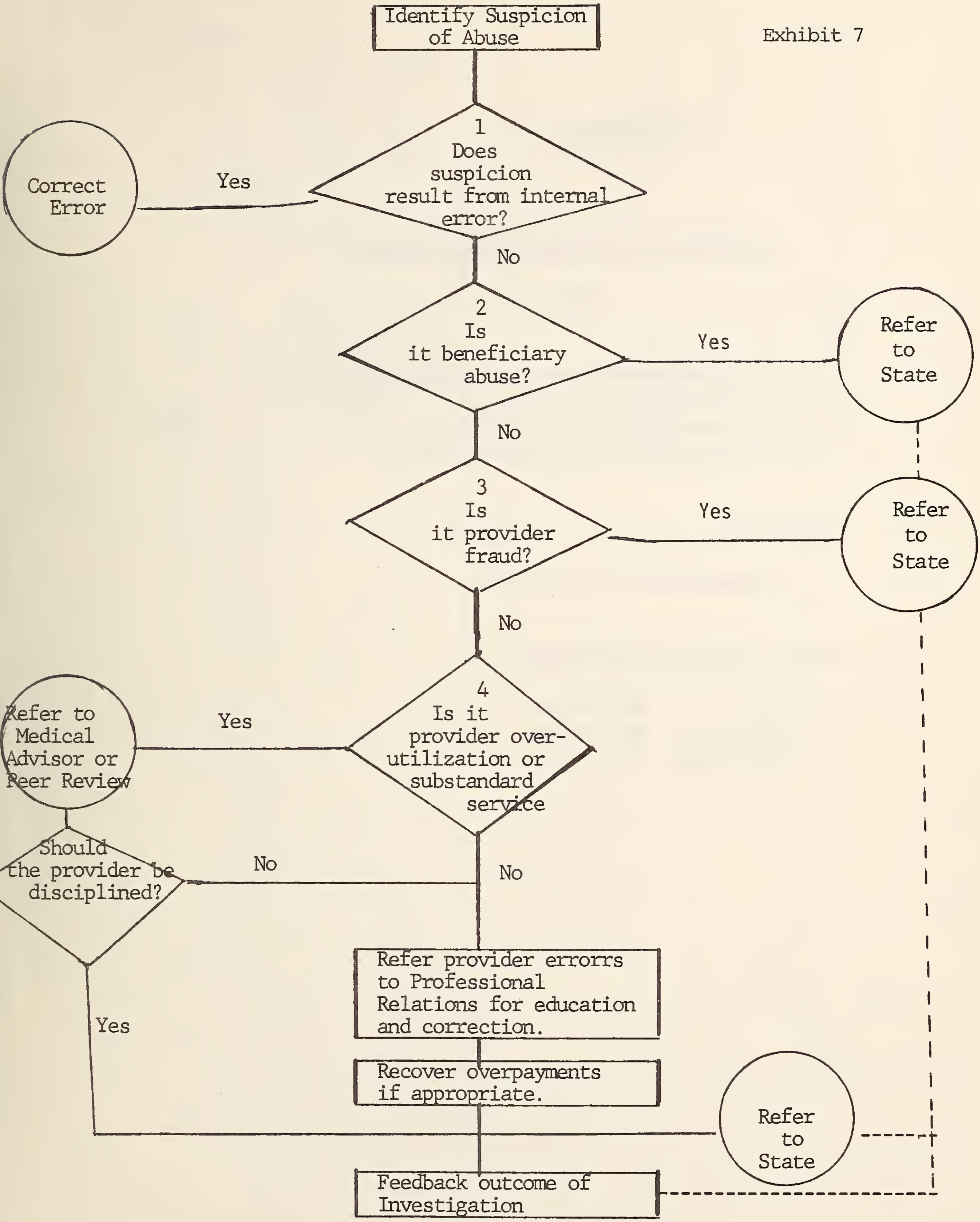

Identify Suspicion of Abuse
1
Does suspicion result from internal error?
Yes
Correct Error
No
2
Is it beneficiary abuse?
Yes
Refer to State
No
3
Is it provider fraud?
Yes
Refer to State
No
4
Is it provider over-utilization or substandard service
Yes
Refer to Medical Advisor or Peer Review
Should the provider be disciplined?
No
No
Yes
Refer provider errorrs to Professional Relations for education and correction.
Recover overpayments if appropriate.
Refer to State
Feedback outcome of Investigation

Exhibit 8

MIO REFERRALS

REFERRAL TO GOVERNMENT AGENCIES

1977-1978

101 Cases Referred to Investigation Section of D.O.H.
2,474 Cases Referred to S.U.R.
2,752 Requests for Microfilm Histories
431 Cases Referred to Beneficiary Abuse

1976-1978

14 Cases Referred to B.M.Q.A.

M.I.O. Medical Review Budget

1978	$4,069,800
Reductions	$29,000,000
Cost/Benefit	7 to 1

SURS QUARTERLY ACTIVITY REPORT

1. Type
2. Due by 5th of month
3. Distribution: preparer, file, Regional Administrator, Headquarters

OTHERS: (specify)*
1.
2.
3.

REGION:
Composite

QUARTER:
3d - 78

PROVIDER TYPE	TOTAL CASES RECEIVED	# ONSITE REVIEWS CONDUCTED	# CASES HEARD IN CASE REVIEW	# CASES CLOSED	# NO ACTION CASES	# WARNING/PROVIDER EDUCATION LETTERS	# REFERRALS TO INVESTIGATIONS	# REFERRALS TO LICENSING BOARDS	# REFERRALS TO A.G. FOR SUSPENSION	# CASES PLACED ON PRIOR AUTHORIZATION	SPECIAL PROSPECTIVE REVIEW (MIO)	# RECOUP CASES & DOLLAR AMOUNT DEMANDED	# SPEAR CASES	REFERRAL TO MEDICARE	FISCAL IMPACT (ESTIMATED DOLLAR SAVINGS)
PHYSICIAN	64	31	26	27	2	0	5*	5*	4	0	13	(14)$374,777 (1)$10,000ea	10	3	(19)$780,049 (5)not comp
HOSPITAL	5	0	2	0	0	0	1**	1	1	0	0	(3) not comp (2)$87,629	0	0	(1)$428,355
PHARMACY	3	5	18	10	0	1	2	14	7	0	0	(13)$778,220 (1) to be re-computed	0	0	(14)$762,357 (1)not comp
OPTOMETRY	65	24	42	14	10	1	0	0	0	0	1	(24)$18,751	16	0	(27)$80,299
CLINICAL LAB	5	1	1	0	0	0	0	0	0	0	0	(1) ***	0	0	(1) ***
O.P. CLINIC	0	0	1	0	0	0	0	1	0	0	0	(1)$419	1	0	(1)$45,419
MEDICAL TRANS.	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0
PSYCHOLOGY	4	4	6	2	0	0	1	0	0	0	1	(4)$3,606	3	0	(4)$2,070
DENTAL	6	22	21	4	1	0	1	2	0	3	0	(16)$45,247 (1)Unknown	0	0	(16)$45,523 (1)Unknown
P. THERAPY	0	0	1	1	1	0	0	0	0	0	0	0	0	0	0
PODIATRY	1	1	2	0	0	0	0	1	1	1	0	(1)to be comp	1	1	(2)$50,000ea
CHIROPRACTOR	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
MED. GROUP	6	1	3	1	0	1	0	0	1	0	1	(1)$2-3,000ea	1	1	(1)$104,126 (1)$10,000ea
MED. EQUIP.	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
X-RAY LAB	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
LAST QUARTER ▷	327	113	101	65	19	8	8	3	3	2	1	(56)$199,012	40	0	(59)$377,059
THIS QUARTER ▷	159	91	125	60	17	3	10	24	14	4	15	(75)$1,319,775 (6) not comp (1)$853 ident	32	6	(89)$3,367,100 (6)not comp
												(166)$1,670,297	97	6	(202)$4,306,[illegible]15

* Referrals w/o onsite or case review.
** Referred to cost watch.
*** Figure to be extrapolated by HEW 3-4 year period

Exhibit 9A

SURS QUARTERLY ACTIVITY REPORT

1. Type
2. Due by [illegible] of month
3. Distribution: preparer, file, Regional Administrator, Headquarters

1. Pulmonary Lab
2.
3.

Los Angeles
QUARTER:
Jul Aug Sept '78

PROVIDER TYPE	TOTAL CASES RECEIVED	# ONSITE REVIEWS CONDUCTED	# CASES HEARD IN CASE REVIEW	# CASES CLOSED	# NO ACTION CASES	# WARNING/PROVIDER EDUCATION LETTERS	# REFERRALS TO INVESTIGATIONS	# REFERRALS TO LICENSING BOARDS	# REFERRALS TO A.G. FOR SUSPENSION	# CASES PLACED ON PRIOR AUTHORIZATION	SPECIAL PERSPECTIVE REVIEW (MIO)	# RECOUP CASES & DOLLAR AMOUNT DEMANDED	# SPEAR CASES	REFERRAL TO MEDICARE	FISCAL IMPACT (ESTIMATED DOLLAR SAVINGS)
PHYSICIAN	28	8	7	5	2	0	0	2	3	0	1	2 $325,797.00	1	0	7 $ 559,667.00
HOSPITAL	4	0	1	0	0	0	0	1	1	0	0	1 $ 86,775.97	0	0	1 $ 428,354.80
PHARMACY	3	2	12	10	0	0	2	13	7	0	0	11 $ 776,944.62	0	0	12 $1,761,687.14
OPTOMETRY	65	24	42	14	10	1	0	0	0	0	1	24 $ 18,751.14	16	0	27 $ 80,298.72
CLINICAL LAB	2	1	1	0	0	0	0	0	0	0	0	1 *	0	0	1 *
O.P. CLINIC	0	0	1	0	0	0	0	1	0	0	0	1 $ 418.58	1	0	1 $ 45,418.58
MEDICAL TRANS.	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
PSYCHOLOGY	4	4	6	2	0	0	1	0	0	0	1	4 $ 3,605.64	3	0	4 $ 2,069.97
DENTAL	6	12	14	4	0	0	1	2	0	2	0	12 $ 35.289.39	0	0	12 $ 35,565.39
P. THERAPY															
PODIATRY															
CHIROPRACTOR															
MED. GROUP	3	0	1	0	0	0	0	0	1	0	0	0	0	0	1 $104,136.00
MED. EQUIP.															
X-RAY LAB															
OTHERS*	0	1	2	0	0	0	1	0	0	0	0	0	0	1	1 $ 58,892.00
MONTHLY TOTAL	115	52	87	36	12	1	5	19	12	2	3	55 $1,247,562.34	21	1	65 $3,076,089.60
Y.	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	98 [illegible]	[illegible]	[illegible]	134 [illegible]

Exhibit 9B

SURS QUARTERLY ACTIVITY REPORT

1. Type
2. Due by [illegible] of month
3. Distribution: preparer, file, Regional Administrator, Headquarters

1.
2.
3.

S[illegible] FRANCISCO
QUARTER:
July-September, '7

PROVIDER TYPE	TOTAL CASES RECEIVED	# ONSITE REVIEWS CONDUCTED	# CASES HEARD IN CASE REVIEW	# CASES CLOSED	# NO ACTION CASES	# WARNING/PROVIDER EDUCATION LETTERS	# REFERRALS TO INVESTIGATIONS	# REFERRALS TO LICENSING BOARDS	# REFERRALS TO A.G. FOR SUSPENSION	# CASES PLACED ON PRIOR AUTHORIZATION	SPECIAL PERSPECTIVE REVIEW (MIO)	# RECOUP CASES & DOLLAR AMOUNT DEMANDED	# SPEAK CASES	REFERRAL TO [illegible]	[illegible]
PHYSICIAN	35	23	19	22	02	0	5*	3*	1	0	11	(12)$48,980 (1)$10,000ca	09	03	(12)$220,382 (5)not computed
HOSPITAL			01		1-Referred to Cost Watch							(3)not computed (1)$853 identified			(1)- 0
PHARMACY		03	06 (-2 pending)			01		01				(1)to be recomputed (2)$1,275			(1)not computed (2)$570
OPTOMETRY															
CLINICAL LAB	03														
O.P. CLINIC															
MEDICAL TRANS.	01	01													
PSYCHOLOGY															
DENTAL		10	07		01					01		(4)$9,958 (1) -???			(4)$9,958
P. THERAPY			01	01	01										(1)- 0
PODIATRY	01	01	02					01	01	01		(1)to be computed	01	01	(2)$50,000ca
CHIROPRACTOR															
MED. GROUP	03	01	02	01		01					01	(1)$2-3000ca	01	01	(1) $10,000 ca
MED. EQUIP.															
X-RAY LAB															
OTHER *															
Monthly Quarter TOTAL	44	39	38	24	05	02	05	05	02	02	12	(20)$72,213 (6)not computed (1)$853 identified	11	05	(21) 291,010 (05)not computed (2) - 0
Y.T.D.	157	157	131	84	25	11	10	10	05	04	1[illegible]	(68) 3[illegible]7,207.40		0[illegible]	

*3 referrals to [illegible] Investigations without onsites or Case Reviews
*1 referral to [illegible] without onsite or Case Review

EXHIBIT 9C

COST AVOIDANCE FROM SPEAR ACTION

This study was conducted to approximate the cost avoidance impact of placing Medi-Cal providers on Special Prepayment Evaluation and Review (SPEAR). The evaluation was limited to physicians and physician group providers, due to incompleteness of data for other provider types.

Surveillance and Utilization Review (SUR) Section initiated the SPEAR process in October of 1977. The intent of SPEAR is to stop inappropriate payments and to correct erroneous billing practices uncovered during the SUR onsite review process, including overcoding for the level of service actually provided; charging for inappropriate or questionable services; and charging for services not medically necessary or not Medi-Cal program benefits. The process is initiated by a letter from the chief of SURS informing the provider that his future claims will be manually reviewed at the fiscal intermediary. The letter specifies that unless appropriate supporting documentation is submitted with claims for the identified questionable services, payment for those services will be cutback to a lesser coding level; or, in the case of unnecessary, nonbenefit or inappropriate services, payment will not be made. Simultaneously, the fiscal intermediary is instructed to conduct the manual review and to cutback payments accordingly.

The fiscal intermediary generates a quarterly report reflecting the actual dollar cutbacks which result from this process. To date, one such report covering January through March 1978 has been received by SURS. (This report does not precisely coincide with SURS records of providers on SPEAR. It included three physician providers not reflected in SUR SPEAR files, and excluded one physician placed on SPEAR by SUR.) For the 14 physicians and 4 physician groups reported, the total quarterly cutback was $25,846.00. This figure does not reflect the overall cost avoidance of SPEAR action because providers usually change their billing practices when confronted by SUR (exit conference and/or SPEAR letter) with their errors. These changes in billing practices decrease the probability of actual dollar cutback.

Study Data:

Readily available data consisted of identification of all physician and physician group providers placed on SPEAR by SURS to date, calendar year 1977 total Medi-Cal revenue and claims volume for these providers, and year to date (1978) revenue and claims volume was available from the MIO on-line provider history file.

Study Group:

The study group consisted of 15 physician providers and 4 physician group providers. These represent all physician and physician groups whose onsite review during 1977 resulted in SPEAR action. The date of initiating SPEAR action for these providers ranged from October 5, 1977 to March 24, 1978; thus, the SPEAR time period for these providers varied as much as six months. For providers who were placed on SPEAR toward the end of March, the year-to-date evaluation took place only 3 2/3 months later. For those placed on SPEAR before January 1, 1978 the year-to-date evaluation covered a 7 2/3 months period.

Study Methodology:

The 1977 claims volume and total revenue information was obtained from available data for each of the 19 providers whose 1977 onsite reviews resulted in SPEAR action. Additionally, their average payment per claim was calculated from this information. Year-to-date CRT reports on claim volume and total revenue were obtained on August 15 and 16, 1978. This represented data on 7 2/3 of the total 1978 payment year. Individual provider claim and revenue projections for all of 1978 were obtained by dividing these figures by 7.6 and multiplying by 12. This gave a slightly high annual projection for 1978 because the divisor was rounded off.

YTD ÷ 7.6 = Average Monthly Payment to Date (AMPD)

AMPD x 12 = 1978 Revenue Projection

The 1977 claims volume, total revenue, and payment per claim were compared to the 1978 projections and the differences noted. (See Attachments)

Study Summary:

Physician Providers

The 15 SPEAR physician providers had a combined 1977 revenue of $1,438,311.00. Their 1978 projection is $1,312,986.00. This indicates a cost avoidance of $125,325.00 or 8.7 percent less revenue. Their claims volume is projected to decrease an average of .1 percent while their payment per claim is projected to decrease an average of 19 percent.

Physician Group Providers

The largest of the four physician group providers (Serra Medical Group) has undergone substantial expansion since the SUR onsite review in September of 1977. At that time there were 42 full and part-time physician providers in the group. Now, less than one year later, the group has sixty-five physicians. This group had a 1977 Medi-Cal revenue of $1,488,147.00. Their 1978 projection is $1,869,578.00 for an increase of $381,430.00. This is fairly consistent with a projected increase claims volume of 28 percent. Their payment per claim is projected to decrease by 2 percent.

The remaining three physician groups together had a 1977 Medi-Cal revenue of $1,283,426.00. Their 1978 revenue is projected at $1,092,392.00 for a cost avoidance of $191,034.00. Their claims volume is projected to increase by two percent, but their payment per claim is projected to decrease by seventeen percent.

Study Conclusions:

1. Special Prepayment Evaluation and Review is an effective SURS sanction. It does not discourage physician and physician group providers from providing services to Medi-Cal beneficiaries. This was reflected in the figures showing a fairly constant claims volume. It does correct or curb erroneous billings and inappropriate payments thru increased review. This was reflected in the comparative revenue and payment per claim figures.

2. Surveillance and Utilization Review Section should establish a regular system to determine cost avoidance effect of its sanctions/actions for all providers who are reviewed. It would be appropriate to record the provider's average monthly revenue, claims volume and payment per claim at the time the decision to conduct onsite review is made. Comparison figures should be recorded nine months later and unexpected changes or discrepencies should be reconciled. This process would serve to provide relevènt cost effectiveness data on the Section's activities and would also provide for follow-up monitoring of providers who were reviewed onsite.

Audits and Investigation Division
Surveillance and Utilization
  Review Section
August 31, 1978

Exhibit 10

DEPARTMENT OF HEATLH
OFFICE OF HEALTH INVESTIGATIONS
YEARLY ACTIVITY REPORT
STATEWIDE

Date: July 18, 1978 Report for the period: FY 77-78

	PROVIDER	BENEFICIARY	TOTAL
COMPLAINTS RECEIVED DURING 1977 (FY 77-78)	4251	7229	11480
PRELIMINARY INVESTIGATIONS			
A. On Hand First of Year	1360	1880	3240
B. Assigned This Year	4073	7073	11146
C. Completed This Year	4125	7290	11415
1. Completed (No Action-Referrals, etc.)	3114	6593	9707
2. Completed - Case Opened	973	697	1670
D. On Hand End of Year	1337	1715	3052
CASE COUNT			
A. On Hand First of Year	556	872	1428
B. Age of Cases on Hand First of Year			
1. Less than 6 months	184	71	255
2. 6 months to 1 year	158	153	311
3. 1 year or older	205	629	834
C. Opened During the Year	972	721	1693
D. Closed During the Year			
1. Criminal Prosecution	14	58	72
2. Accusatory Proceedings	38	-0-	38
3. Recovery	74	382	456
Amount	$504,337	$578,973	$1,083,310
4. Warning Letter	300	78	378
5. Verbal Warning or Instruction	303	10	313
6. Allegation Unconfirmed	193	296	489
7. Other	91	253	344
8. TOTAL Cases Closed	1013	1078	2091
E. On Hand End of Year *	475	511	986
F. Age of Cases on Hand End of Year			
1. Less than 6 months	209	227	436
2. 6 months to 1 year	142	104	246
3. 1 year or older	153	197	350
A. Cases Pending at A.G. First of Year	96	-0-	96
B. Cases Filed with A.G. this Year	61	-0-	61
C. Cases Pending at A.G. End of Year	91	-0-	91
Criminal & Civil Complaints filed this year	34	97	131

* Non additive due to corrected case count by District Offices July 1977

Exhibit 11

HEALTH INVESTIGATION SECTION

SIGNIFICANT ACTIVITY 1978

	L.A.	Santa Ana	S.F.	Fresno	Total
Criminal Convictions (Provider)	5	6	2	0	13
(Recipient)	4	0	0	1	5
Provider Suspension	6	1	0	1	8
Provider/recipient overpayments of over $5,000.00 referred to Recovery Section	31	11	3	4	49

Exhibit 12

MEDI-CAL FRAUD UNIT

7/1/78 - 12/31/78

	SAN FRANCISCO	SAN DIEGO	LOS ANGELES	SACRAMENTO	TOTAL
FILED	1	2	8	4	15
CONVICTED	1	1	1	2	5
OVERPAYMENT		1	6		7

State of California Department of Health

Memorandum

Exhibit 13

To : All Employees

Date : December 15, 1976

Subject: Department of Health Incompatible Activity Statement

From : Office of the Director

The Department has just completed a proposed Incompatible Activity Statement. Public hearings will be held in Sacramento on January 18, 1977, at 10:00 a.m. in the Auditorium of OB 8, at 714 P Street; in Berkeley on January 21, 1977, at 10:00 a.m. in Room 123 at 2151 Berkeley Way; and in Los Angeles on January 25, 1977, at 10:00 a.m., in Room 1138 at 107 South Broadway. The purpose of hearings will be to allow comment on the proposed statement by all interested employees. Written comments may be directed to the Labor Relations Section, 744 P Street, Room 892, Sacramento, CA 95814.

All interested employees are encouraged to attend the hearings and may be granted time off to do so. No per diem or expense allowance will be allowed. This new policy was developed because the existing policy is not up to date; it is not sufficiently specific to provide adequate guidelines to either managers or employees; and it does not meet current departmental needs and concerns such as were identified by the "Little Hoover Commission" and recent Department of Health investigations.

Copies of the statement have been sent to all unit supervisors and are available to all employees. The following is a brief analysis of the statement as it relates to employees:

The Department has divided incompatible activities into two categories:

1. Those activities that are declared to be incompatible or in conflict with their duties as State employees and that are strictly prohibited, and
2. Those activities that are presumed to be incompatible and in conflict with their duties as State employees and that will be prohibited, unless the employee can show a reason otherwise.

Those activities that have been declared to be incompatible or in conflict with the duties of a State employee are:

A. Receiving compensation from the State and from another source for work done over the same period of time. This does not apply to an employee's vacation time, compensating time off, or military leave.

B. Using his or her official position for personal gain.

C. Using departmental records for private gain, or divulging confidential departmental information or records, unless officially authorized to do so.

D. Using during or outside of official hours, any departmental files, badge, identification card, records, information, facilities, staff time, equipment, etc., for personal gain or advantage or lending such items to clients, contractors, providers, or other persons.

E. Claiming travel expense for other than State business.

F. Initiating contact with State administrators or legislative personnel for the purpose of presenting the Department's policy or position unless it is part of the employees' official duty.

G. Seeking or receiving any gratuities, or gifts, or personal loans, or special discounts from any organization, firm, or person that is subject to regulation, inspection, supervision, licensing, certification, or audit by the Department or by any local agency under the supervision of the Department.

H. Receiving or accepting money or any other consideration from anyone other than the State for the performance of an act which the employee would be required to render in the regular course of his/her State employment.

I. Engaging in partisan political activities which are prohibited by the Federal Hatch Act or by applicable State statutes. Further information on which political activities are prohibited and which are permitted is contained in Appendices A and B of the Incompatible Activity Statement.

All employees desiring to engage in outside employment on their own time are required to receive specific written approval from their Division Deputy Director, or Designee. An employee who plans to engage in any outside employment must submit to his/her supervisor a request to engage in such employment. The employee's supervisor must submit the request, together with any recommendation, to the Deputy Director or Designee, within five (5) business days of the receipt of the request from the employee's supervisor. Should the employee fail to receive a written decision within twelve (12) business days after submission of his/her written request, permission to engage in outside employment shall be deemed granted.

The following are activities that are presumed by the Department to be incompatible and for which exemptions must be granted:

1. Continuous full-time outside employment, in addition to State employment, or continuous outside employment (part-time) which results in working more than 12 hours a day, including State service.

2. Any outside employment supported by funds which are either approved or administered by the Department of Health, even though the employee has received permission to engage in outside employment.

3. Consultation or services, for pay, by an employee licensed to practice in one of the healing arts, to any patient, resident, or client of a Department facility or program until one year after the time of the last discharge from such facility or termination from such program.

4. Performance of any act (other than in his/her capacity as a State employee) knowing or having reason to know that such act may later be subject directly or indirectly to the control, inspection, review, audit or enforcement by the employee or the Department or any local agency under the supervision of the Department.

5. Performance of private consultation activities for any person to whom the Department refers patients. Private consultation for patient planning for any person when such responsibility is the function of the Department or any local agency under the supervision of the Department.

6. Ownership or participation (as a partner, employee, officer, consultant, contractor, board member) or financial interest in any business institution, or agency that has a financial relationship with the Department or that is subject to regulation, inspection, supervision, licensing, or certification, by the Department; or in any local agency under the supervision of the Department. Prohibited businesses include, but are not limited to: nursing homes, residential and intermediate care homes, proprietary hospitals, drug stores, ambulance services, pharmacies, clinics and clinical laboratories.

Exemption requests for any of the above outside employments presumed to be incompatible must be submitted to the Division Deputy Director or his/her designee for approval.

Any employee who is denied permission to engage in an outside employment may seek review of the denial by the Deputy Director, Legal Affairs. If an employee engages in such an activity without seeking review, it will be deemed that he or she is engaged in an incompatible activity.

Written requests for review must be provided in triplicate. One copy is retained by the requesting employee; one copy goes to the employee's supervisor; the original is to be forwarded to the Deputy Director, Legal Affairs, Room 1216, 714 P Street, Sacramento, CA. Should the employee not receive a decision from the Deputy Director, Legal Affairs, within thirty (30) business days from the notice of receipt of the request, the employee may deem the request for exemption granted.

Sincerely,

Jerome A Lackner MD

Jerome A. Lackner, M.D.
Director of Health

Exhibit 14

CASE FILES

A case investigation file will be prepared immediately on all cases opened. It will be maintained in three locations: (1) in the district; (2) by the investigator; (3) by Section Headquarters. The files are to be maintained as confidential at all times and are to be kept in locked files or other secure means when not in use or under watch.

The case file will include the complaint report and all reports of investigation or agent reports pertaining to the case. Criminal cases shall also include a current criminal action report. It is advisable where there has been news coverage on a specific case to include newsclippings in the file.

Progress reports. A written report must be in each file indicating significant investigative action. The District Supervisor will submit quarterly, a status report on all cases pending action with District Attorneys, Courts, and the Attorney General. This will consist of a follow-up contact with the appropriate authority, and a status report on the findings. The District Supervisor will maintain a tickler file on these cases to assure prompt follow-up and reporting. Significant investigative action to be reported will include prompt reporting of long stays, convictions and sentences.

Case files will be maintained uniformly in all districts and by Section Headquarters. Each file will be in legal-sized manila folders and will be filed by case number in numberical order.

Districts, upon opening a case, will complete a file label and file card for Headquarters' use in the form designated by Headquarters and will forward the label and card with the Headquarters' copy of the case.

OPEN CASES

District offices shall retain the original file on all open cases for as long as the case remains open.

Headquarters shall retain a duplicate file on all open cases for as long as the case file remains open.

CLOSED CASES

District offices shall retain the original file on all closed provider cases and action beneficiary cases for three years. These closed cases more than three years old will be purged from the district files each July and sent to Headquarters. Beneficiary no action cases will be purged by the districts and Headquarters upon closure and destroyed. Headquarters shall sort out and permanently retain the files of convicted and suspended subjects and the files of subjects sent warning letters. Duplicate case files more than three years old shall be purged and shredded. District offices and Headquarters shall report by June 30 each year to Paperwork Management Unit, Management Consultation Section, the accumulated cubic footage of records purged and destroyed.

By June 30 each year, Headquarters and district offices will submit a Records Inventory on Records Inventory Worksheet", Standard Form 70, to Paperwork Management Unit. This inventory will include an office sketch identifying storage and file facilities, and identification of all records on hand and inventoried.

Records Transfer Lists, Standard Form 71, and Records Disposition Schedules, Standard Form 73, will be completed on a current basis as records are purged and transferred to the State Records Center.

REGION IX

DEPARTMENT OF HEALTH, EDUCATION AND WELFARE

HEALTH CARE FINANCING ADMINISTRATION

MEDICAID BUREAU

Claims Processing

CALIFORNIA STATE ASSESSMENT

November, 1978

Participants: Mary Canale (RO/Medicaid)
Art Miles (CO/Medicaid)
Tom Munk (RO/Medicaid)

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CALIFORNIA CLAIMS PROCESSING

Executive Summary

Since 1966, when the Medi-Cal Program was first implemented, the State has had its claims processing activities performed under contract with the same fiscal intermediary, Medi-Cal Intermediary Operations (MIO). The MIO has three claims processing locations:

1) San Francisco - Blue Shield - For statewide professional claims.
2) Oakland - Blue Cross North - For institutional claims from providers in northern California.
3) Woodland Hills in the Los Angeles area - Blue Cross South - For institutional claims from providers in southern California.

Electronic Data Systems (EDS) is the MIO data processing subcontractor. All MIO automatic data processing occurs at the EDS site co-located with Blue Shield in San Francisco.

The MIO now processes approximately 3.5 million claims per month for the State, as shown:

CLAIMS VOLUME FY 77-78

Blue Shield

Physician	1,278,853
Drug	1,253,461
Medical Transport	37,724
Other Medical	289,361
Other Services	45,242
Total Processed (August 1978)	2,904,641
Total Processed FY 77-78:	35,276,271

	Blue Cross South	Blue Cross North
Community Hospital		
Inpatient	46,784	19,764
Outpatient	153,651	101,466
County Hospital		
Inpatient	9,892	7,628
Outpatient	56,501	52,604
Nursing Homes	54,852	31,697
Intermediate Care	3,313	1,122
Home Health	1,494	1,100
Outpatient Clinics	18,457	23,120
Out-of-State	1,060	871
Total Processed (August 1978)	346,004	239,372

Total Processed FY 77-78	4,036,053	3,093,19

Total Processed all Plans FY 77-78: 42,405,521

Note: State Hospital (109,000 claims per year) and Dental (1.5 million claims per year) claims processing activities were excluded from this review.

The MIO contract, never competitively awarded, has been continuously renewed since 1966. The MIO is a non-profit organization, charging the State for its services on a cost-reimbursable basis. The ADP subcontractor to MIO, EDS, is a profit-making organization and charges MIO for its services according to claims volume and a rate structure based upon the "processed billing unit" (PBU). The actual cost to the State for the MIO contract in FY 77-78 was:

Blues	$28,331,527
EDS	$14,272,223
Total MIO	$42,603,750

The State requested MMIS certification for its Medicaid claims processing operations in 1974. After two DHEW on-site certification reviews, the State was notified that its system met all requirements for certification, with the one exception that the State did not issue to all beneficiaries the explanation of benefits (EOB) as required by law. On January 1, 1978 a change to the EOB requirement in the law became effective, allowing issuance of EOBs on a sample basis. In January 1978, the State began to issue EOBs and again requested MMIS certification. In November of 1978, after DHEW systems review, the State's claims processing operation, under the MIO fiscal intermediary contract, was found to be certifiable, retroactive to January 1978.

The State established the Medi-Cal Procurement Project (MCPP) in January of 1977, in order to develop an improved fiscal intermediary contract which was to be made subject to a rigorous competitive procurement process. For an overview description of the new contractual arrangement, refer to the MCPP "Presentation to the Joint Legislative Budget Committee Hearing of January 17, 1978" (see Attachment #1). The 19-month procurement process culminated in an award of a 5½ year fiscal intermediary contract to Computer Sciences Corporation (CSC), the low bidder. A comparison of the CSC contractual arrangement to costs which would have been incurred if the State remained with the MIO contract was completed and the State has estimated that at least a $100 million administrative cost savings will be realized under the CSC contract.

The CSC contract began on September 1, 1978. Phase-in of CSC claims processing operations, and phase out of MIO's operations, will occur by claim type as follows:

Claim Type	Installation Date
Drug	June 1979
Long Term Care	September 1979
Inpatient/Outpatient	December 1979
Medical	March 1980

The State intends to maintain its MMIS certification under the CSC contract. The phase-in of CSC's operation, and phase out of MIO's operation, has placed a severe strain on State DHS personnel resources. During this period of contract conversion, the State must work with both intermediaries to insure that the claims processing function is not degraded.

During our review of the current claims processing operations under the MIO contract, we visited all three claims processing locations: the EDS data center, the State's Fiscal Intermediary Section in Sacramento which has the responsibility for insuring that MIO performs in accordance with Federal/State Medi-Cal regulations, and one State field office location in San Francisco where some of the State S/URS and TAR approval staff are located.

The overall impressions gained from this review are somewhat disturbing. The MIO claims processing activities have evolved over time in response to changing environmental and program exigencies. The result is a patchwork of operations which lack systems "wholeness or integrity". Current operations are too far flung and procedures too poorly documented to facilitate adequate State/Federal monitoring and control. Too many manual operations are performed by too many claims examiners, causing inefficiencies and leaving room for errors to occur. The MIO operation does work, i.e., claims are processed in a timely fashion. Given the sheer volume of Medi-Cal claims and the complexity of program regulations, the MIO is to be commended for its timeliness in claims payment. But this is not the only criteria for judging the effectiveness of the MIO. Administrative costs are high; and the potential for program dollar losses does exist, as noted in our findings.

The specific review findings noted hereafter are applicable to the claims processing operation under the MIO contract. However, because the MIO operation will phase out within the year, we are of the opinion that corrective actions recommended herein be implemented under the CSC operation, unless otherwise specifically noted.

1. Finding

Blue Cross North and Blue Cross South are responsible for processing and monitoring provider claims for inpatient and outpatient hospital services. Surveillance/utilization review reports for these hospital claims are inadequate. MIO is unable to detect provider abuse of a specific procedure using the MMIS reports, e.g. if a hospital is repeatedly billing for extended examinations, the system is unable to detect the number of occurrences without manually screening individual claims or using contractor-generated special reports. S/UR reports in connection with institutional outpatient services, as presently formulated, are of little value because the data reflected is not specific. Only the number of recipients served, dollars invoiced, dollars paid, services billed, services paid, number of prior authorizations, etc., are listed.

Recommendation:

The State is aware of the requirement to improve the S/UR system reports and has continuously strived to do this. These efforts should continue throughout the remainder of the MIO contract. Under the CSC contract, an advanced S/UR capability is being delivered. We recommend that a schedule be developed and that selected MIO provider history files be converted to the CSC format and that this data then be run through the new CSC advanced S/URS subsystem. The results from these runs should be used to follow-up on provider fraud and abuse which has remained undiscovered in the past. Federal financial participation would be available at 75% for these S/URS historical runs.

2. Finding

The State did not respond in a timely manner to a routine data request which delayed completion of portions of the Claims Processing Review. Recipient History Reports (MIO Reports 6005) dated on November 2, 1978, were not delivered to the reviewer until the afternoon of November 17, 1978. This negated the conducting of an independent random/judgmental claims sample. Records maintained by the State Certification Office, which has personnel on-site to review claims as a back-up to the claims payment certification process were reviewed in lieu of a federal claims sample being performed. The sample, while statistically invalid, involves the monthly sampling of more than 1,000 claims selected on either a random or judgmental basis from the remittance advices prepared for providers. The samples taken over the past 7 months indicate that erroneous payment situations exist. A concentrated effort is required to determine their ratio of occurrence, and the potential loss of program dollars resulting from their existence. The effectiveness of the edits and audits employed by the fiscal agents could not be verified without a statistically valid claim sample. Evidence of: 1. duplicate payments, 2. conflicting policies on payments for certain procedures by the different fiscal agent locations, and 31 erroneous payment situations existing due to the inclusion of 1969 relative value studies (RVS) codes in the data base for institutional providers and the edict for all providers to bill using 1974 Relative Value Studies codes, were detected by the State Certification Office representatives. As a result of interviews with State Certification Office representatives, we were not satisfied that the State DHS Fiscal Intermediary Section was following-up on reports provided.

Recommendation:

This finding highlights the problems encountered in assessing the performance of a large State and States having more than one fiscal agent. The volume of claims processed monthly in California (approximately 3.5 million) dictates that at least .01% claims sample be extracted and extrapolated over the universe in order to produce acceptable inferences. Therefore, it is recommended that the DHS Fiscal Intermediary Section perform a follow-up "focus" type review keying on erroneous payment situations already identified by the State Certification Office on-site representatives. The review should determine the ratio of identified overpayment situations and the effectiveness of existing edits and audits. An alternative would be to direct an independent audit after identification of overpayment situations that will remain after the transfer of contractor responsibility. Either method selected should be completed prior to transfer of the claims processing function to the new contractor.

3. Finding

The MIO has indicated that 9.5% of claims processed by Blue Shield must be returned to providers for additional information. At Blue Cross North, the percentage of returned claims was reported to be 7% At Blue Cross South, this figure was reported as 20%.

Recommendation:

The State should direct a study to determine why the return rate at Blue Cross South is 13% higher than at Blue Cross North. Providers found to have contributed most to this return rate should receive special training to correct inappropriate billing practices.

4. Finding

In August of 1978, Blue Shield instituted the "Error Status Code Project", a claims examination quality control project. The Daily Batch Error Report is examined for significant changes in claims examiner errors. Batches of claims, with a high incidence of error rates, are pulled and examined to determine the error's cause. Claims examiners are informed of their errors and corrective actions instituted. The EDS is notified if a systems error appears to be causing the problem. The feature which distinguishes the "Error Status Code Project" from other MIO quality control programs is that graphs are used to visually display the mean error rate before and after corrective actions are taken, thus providing documented evidence of the success or failure of problem definition and corrective actions taken.

Recommendation:

The "Error Status Code Project" should be continued and expanded, under both MIO and CSC, to include all types of errors, e.g.provider, data entry and systems error status codes. Under the current project, the graphs used to display the "Daily Batch Error Report" error status codes are now hand prepared. We recommend that CSC consider automating the preparation of these graphs. Automated graphics would relieve quality control staff from preforming this tedious function and allow them to concentrate on the error causes and corrective actions necessary.

5. Finding

Treatment Authorization Request (TAR) blank forms are uncontrolled. Claims examiners looking for TAR authorizations do not check the TAR signature for a valid State representative's authorization. There is no official State seal affixed to TARs to indicate that TARs have been properly approved. In short, there is nothing to prevent dishonest providers from completing their own TAR and then attaching it to their claims.

Recommendation:

The State's TAR system should be reviewed for the purpose of instituting TAR controls to preclude provider TAR approval falsification.

6. Finding

Upon request, provider and recipient profiles are generated by MIO for the following organizations:

State Investigations Unit
State Attorney General
DHEW Audit Agency, Program Integrity, Medicaid, Medicare
California Board of Pharmacy
California Board of Medical Insurance
State and Federal Food and Drug Administration
General Accounting Office
Federal Bureau of Investigation
PSROs

In discussions with MIO staff, it was discovered that all of these various agencies, and other special investigative task forces, can receive profiles directly from MIO without continuing to receive DHS special clearances. Also, no attempt is made to track individual profile requests among the various agencies to avoid duplicate investigations and report generation costs. Also, our own experience with gathering sample profile data from MIO leads us to the conclusion that this information is inadequately safeguarded (e.g., profiles generated on November 2 were lost in transit and remained undelivered for two weeks).

Recommendation:

The State should institute a special task force to examine actual practices now existent with regard to recipient and provider profile deliveries. All individuals within the various agencies should be specifically cleared to receive this information, and this clearance should be reverified for each individual on a regularly scheduled basis. The various agency requests should be coordinated whenever possible. Recipient and provider profiles should never be transferred through routine mailings, but should require special delivery practices.

7. Finding

The on-site review of front-end claims examination areas and contacts with claims examination quality-control staff at all three MIO locations reveals than an excessive amount of manual claims review and coding occurs prior to data entry and automatic data processing. This is not a new revelation, but rather appears to be an age-old problem with medical claims processing systems. The MIO has instituted an extensive claims examiner training program, and quality-control procedures to correct claims examiner errors.

Recommendation:

Under the CSC fixed-price contract, the contractor has a built-in incentive to keep manual claims examination to the minimum in order to reduce costs, thus insure profits. For example, the contractor plans to make use of optical scanning techniques and to require providers to do their own diagnostic coding. The CSC should be encouraged and supported in its efforts to maximize the use of automatic data processing technology to reduce costs, error rates, and claims processing cycle time.

8. Finding

Recipient History Reports(MIO Report 6005) lack basic personal identification data upon which system edit and audit checks are based. Approximately 120 Recipient History Reports were reviewed and more than one-fourth (33) had the year of birth field coded "00". The sex code indicator was found to be incorrect in some instances. In one case noted, a key data entry erroron basic recipient identification led to the system's creation of a new recipient history record and a duplicate payment rather than to an audit against that recipient's record, already existent in the history file.

Presently, no single on-line eligibility file is accessible to the fiscal intermediary. Therefore, the recipient subsystem history file and claims processing edits/audits are dependent upon the eligibility information contained on the Medi-Cal eligibility labels, and on the accurate key data entry of recipient identification from that label. A history record is created for a recipient when the first claim is entered into the system.

Besides key data entry errors on recipient identification, another source of inaccurate recipient records could be the approximately 300,000 eligibility labels issued each month by the 58 County public welfare offices on an emergency basis. By their very nature, being issued manually on an emergency basis, these 300,000 labels are a potential source for the incomplete and inaccurate data contained in the recipient history.

Incomplete data in recipient history files creates an overpayment situation that will remain until a cyclic record purge schedule is established, and procedures are developed to actively pursue recovery of funds for overpayments caused by incorrect and incomplete personal identification data in recipient history records.

Recommendation:

Ideally, a computer program should be developed now to allow for the purging of data fields which are essential to the performance of computer edits and audits. However, the absence of an extract eligibility file to verify eligibility data entering the system presently negates making that recommendation.

With the phase-in of the CSC contract, the State will provide an extract sequential tape eligibilty file to CSC for eligibility verification. By 1980, the State will have completed plans for the creation of an on-line eligibility file, accessible to the fiscal intermediary and to the counties for the automated generation of emergency identification cards. Under the CSC contract the eligibility file should be used as the only source of eligibility verification and as a source for data elements in building recipient history records and in perfoming edits and audits. Data from the labels on the claim document itself should be used only for an initial eligibility file match. In converting recipient history from the MIO to the CSC file format, a purge of inaccurate data should occur and a study should be initiated to determine if the State can recover funds for overpayments caused by incorrect and incomplete personal identification data in MIO recipient history records.

9. Finding

"Companion claims," (claims wherein supplemental insurance coverage is being paid by a recipient who is also entitled to Medi-Cal benefits) are being paid without verification of third party liability. Claims received from out-of-State providers which indicate companion care or third party coverage are simply being returned by the fiscal agent to the provider with a request to bill third party resources. Providers are returning the claims without indicating that efforts have been made to collect from the third party. The fiscal agent has no alternative under present guidelines, but to pay claims resubmitted by the provider.

Recommendation:

Companion claims which indicate that potential third party liability exists should be returned to providers with instructions to contact/bill the third party resource. They should provide the fiscal agent a copy of correspondence confirming that the effort was made, and copies of responses from the third party resource. This correspondence should be attached to the resubmitted claim. The fiscal agent should pay the resubmitted claim, and forward a copy of the claim to the State recovery unit for follow-up action. This action should be instituted now and should continue under the CSC contract.

10. Finding

The Electronic Data System (EDS) "Disaster Recovery Plan", dated March 31, 1978, does not provide a telephone number for the Title XIX emergency contact.

Recommendation:

The State Agency should provide this information to EDS; and EDS should establish a time table for insuring that all emergency contact information is accurate and up-to-date.

11. Finding

The MIO did not provide a response to the following questions (from the State Assessment questionaire, page VII-29):

> "3. How does State assure that Medicaid isn't reimbursing an HMO for services paid for by Medicare or another insurance company? Does the HMO submit periodic invoices which detail services rendered?"

Recommendation:

The DHS staff should research this question and provide the Regional Office with a report on same.

Attachment

PRESENTATION TO THE

JOINT LEGISLATIVE BUDGET COMMITTEE

HEARING

JANUARY 17, 1978

MEDI-CAL PROCUREMENT PROJECT

REQUEST FOR PROPOSAL

DEPARTMENT OF HEALTH
MEDI-CAL DIVISION

Thank you for the opportunity to discuss the Medi-Cal Procurement Project with your committee. Today we would like to tell you what we are doing, why we are doing it, what our present status is and, finally, present a number of issues that have arisen and explain the Department's position on them.

This effort represents another of the major initiatives which will bring about fundamental improvement in the State's ability to manage the Medi-Cal program. These have included the comprehensive financial audit of Electronic Data System Federal Corporation, the principal supplier of EDP services to the program and the renegotiation of the existing fiscal intermediary contract with the present prime contractor, Medi-Cal Intermediary Operations (MIO). This latter effort will insure, along with accomplishing other major objectives, that there is continuity of program services during the critical transition from the present to a successor contractor.

Since 1966, when the Medi-Cal Program was first implemented, the State has had its claims payment activities performed under contract by the same fiscal intermediary. In the ensuing twelve (12) years, the contract has never been successfully recompeted. In 1975, the administration determined that an open, competitive procurement should be conducted in order for the State to realize substantial improvements in the management and cost aspects of the program that experience had indicated were now possible.

This RFP is the process by which the Department will select a successor fiscal intermediary. It is through the new contract that the Department of Health (DOH) will obtain the safeguards the State requires for program and administrative cost containment and effective contract management.

Legislative authorization for RFP development was received in October 1976. By December 1976, the Department of Health had assembled a professional project staff to prepare the required document. The statutory authorization for the Department to enter into this contract is found in the W&I Code §14104.3. The RFP will permit qualified firms to compete openly for the award of the largest single contract that is let by California government. To date, extensive dialogue with vendors in this field indicates that the State may expect competitive bids from four to six proposers, all with the necessary resources to conduct an enterprise of this magnitude.

As reported to the Legislature in September 1976, the administration believes that the State's interests presently are best served by continuing to contract within the private sector for Medi-Cal claims processing. We recognize that there is much room for improvement in the State's fiscal and management control over the contractor. We also believe that as a result of awarding a new contract, the State will be in a realistic position to administer the claims processing directly should future events dictate that course of action.

The following summarizes, for your consideration, the major features of the RFP that provide significant improvement over the present arrangement:

1. The estimated price of the current contract for fiscal year 77/78 is $43.8 million. In the three preceding budget years, it has been $38.3, $36.1 and $33.8 million respectively. Attempts to determine if these costs are greater than necessary have been unsuccessful. We believe that an open, competitive process attracting highly capable firms will allow the "marketplace" to determine the lowest price we can achieve. We are confident that our present effort will result in a substantial reduction in overall administrative costs in Medi-Cal as compared to any other options available to us.

2. Allocation of financial risk between the State and the Contractor.

The payment basis for the present contract is termed "no profit - no loss". Basically, this entitles the contractor to recover virtually any cost incurred in administering the contract. (Some indirect overhead costs may be disallowed by the State audits.) This arrangement provides no realistic incentive for the contractor to reduce operating costs since the contractor encounters no risk. Should the subcontractor reduce operating costs, there is no mechanism available for the State to share in the reductions. Further, under this "no profit - no loss" basis, the contractor believes that they are entitled to cost overruns resulting from their own errors.

The new contract will allocate a reasonable degree of risk from the State to the new contractor. Major improvements include:

A. The vast majority of contractor reimbursement will be at a firm fixed price for the period of the contract. (RFP Section 3.0)

B. For the relatively minor portions of reimbursement that are based upon the contractor's costs, predetermined cost standards will be specifically defined. (RFP Section 4.20 and 4.11.2)

C. Within reasonable limits, the contractor will be liable for monies paid to providers as a result of contractor errors. (RFP Section 4.15.2)

D. The contractor will incur financial penalties for late performance (RFP Section 4.28.1), and poor performance as evidenced by failure to meet performance criteria (RFP Section 4.28.2). The contractor will also incur financial penalties if, due to their sole fault, the system fails to obtain maximum Federal Financial Participation (RFP Section 4.27).

E. A contractual mechanism is provided to allow the State to share reasonably in efficiencies introduced by the contractor's innovativeness and concurrently provides an incentive to induce the contractor to increase efficiency (RFP Section 4.10).

3. Contractual vehicles to allow improved State management and control of the Contractor.

   A. The present contract gives the State the right to audit the prime but not subcontractors. The new contract will give the State audit access to all tiers of contractors, prime and sub, with the two minor exceptions. (The two exceptions have adequate independent safeguards to insure reasonable expenditures of State funds.) (RFP Section 4.20-4.22)

   B. Medi-Cal is a dynamic program characterized by frequent statutory, regulatory and policy changes. The Department believes it must exercise rigorous control over the direction and implementation of such changes. Under the current contract, the Contractor believes it is entitled to introduce changes and be reimbursed for same without prior State approval. The Contractor further believes it is entitled to refuse to implement a State directed change under certain circumstances.

      Under the new contract, for those changes within the general scope of the contract, the State will have an unequivocal right of prior approval. Further, the Contractor will be required to implement a State directed change without regard to their view of it. (RFP Section 4.6-4.8)

   C. Under the present contract, the only means for either party to resolve disputes is to seek judicial relief. Such procedures are lengthy and the State cannot be assured that its position will prevail during disputes resolution under the present contract.

      Under the new contract, an administrative procedure with adequate safeguards for impartiality and due process is provided for resolution of disputes. Generally, the Director of the Department's decision will be final and not appealable to the courts absent gross error or serious misconduct upon the part of the Director. Appeals arising out of financial audits will follow the procedure set out in Department of Benefit Payments regulations which provide for set-off, interest, etc. For either dispute procedure, the contractor must perform according to the State's direction until the issue is ultimately decided. (RFP Section 4.11)

   D. The Contractor can unilaterally terminate participation in the current contract without penalty and without provision for continuing program operations upon 60 days written notice. This situation is intolerable where the State has no possibility of replacing these services in this timeframe.

      Under the new contract, the Contractor has no termination rights. The State will be able to terminate the Contractor either for default or for the convenience of the government. In the latter case, the Contractor is entitled to certain prescribed termination costs. (RFP Section 4.2.2)

E. Under the present contract, it is virtually impossible to determine, with any specificity, the performance obligations of the Contractor.

The new contract, by requiring a highly detailed response to comprehensive tehcnical and operational specifications, eliminates this vagueness. Additionally, objective performance standards are set out wherever possible.

F. The present Contractor believes that it is hired to set policy for substantial portions of the Medi-Cal program.

The new contract makes clear that it is the State's sole and exclusive prerogative to establish and enforce program policy.

G. The quality, accuracy and acceptability of data has been a serious problem under the present contract.

The new contract provides for full access by the State to all data (RFP Section 4.21.2) and makes provision to insure the quality and accuracy of the data (RFP Section 2.5), and requires that system documentation always be in the possession of the State. (RFP Section 4.14)

H. The new contract makes it mandatory that the Contractor be continuously in compliance with changing State and Federal laws and regulations. (RFP Section 4.30 and 4.31)

4. Claims Processing System Enhancements.

In addition to providing for fundamental reform of the fiscal and contractual aspects of our present arrangement, the Department is seeking major improvements to this complex system. As a result of the implementation of these system's enhancements, the Department will significantly improve its control over the operations of the program and the expenditure of benefit dollars. Some of the major areas in which we seek improvement are set forth below:

A. Federal Specifications -- The system is designed to meet Federal requirements for increased funding (75% rather than 50%).

B. Prepayment Controls -- Comprehensive prepayment controls and adjudication criteria are required.

C. Coding Structure -- The use of 4 digit ICDA diagnostic codes and 1974 RVS procedure codes for reporting will enhance the data base and increase utilization controls and audit capabilities.

D. Automated TAR -- Automated processing of prior authorization documents will reduce provider paperwork and control multiple services.

E. Data Entry -- Capability for tape billings and tape notifications of claim adjudication is required. Innovative data entry methods are suggested.

F. Performance Standards -- Specific standards regarding turnaround time, override codes, microfilm quality, etc., are established.

G. Provider Enrollment -- Provider agreements will be utilized in the provider certification process.

H. Provider Relations -- A provider orientation and billing manual will be required.

I. Medical Review -- State will set and approve all contractor utilized medical policy, and will perform ongoing control, monitoring and audit of the Contractor's medical review function.

J. Surveillance and Utilization Recipient Subsystem (S/URS) -- The State owned S/URS report package will be improved to require flexible report formats at user option. A Treatment Analysis Module will be developed to further control fraud and abuse.

5. Position the State for Future Direct Operation of the Claims Processing System.

A major objective of this procurement is to insure that the State is delivered a product that can be operated within State government should we make that decision in the future. A State takeover of the present MIO system is not feasible.

The new contract will require the Contractor to develop the EDP system in technology with which State personnel are familiar. The Contractor will be required to document fully the system in accordance with State supplied standards and to keep the documentation current. This will permit the State to (a) assume operations with the current training level of State data processing personnel, and (b) minimize the problem associated with conversion should the State use incompatible data processing facilities. The State will have full ownership rights to the entire Contractor produced system and the Contractor shall be obligated to train State personnel in systems maintenance and operation.

In addition, the Department will increase its on-site participation at the new Contractor's facility for purposes of both improved monitoring and control and to gain familiarity with all aspects of systems operations.

PROCUREMENT PROCESS AND STATUS

The award of government contracts of this size and scope are difficult undertakings. The procuring agency is closely scrutinized to insure that the evaluation and selection process is open, impartial and objective. All prospective bidders must be placed upon an equal footing. The Department has made every effort to insure that this be so.

In addition to other considerations, we have:

- . widely advertised our intentions in national media.
- . issued a preliminary RFP to obtain the views of prospective bidders and various governmental entities.
- . conducted bidder's conferences and supplied court reporter transcripts of same to all participants.
- . provided a complete library of all relevant program history and information and encouraged its use by vendors.
- . met with executives of all interested firms to explain our objectives and processes.
- . made available departmental staff to meet with vendors to clarify and supplement written documents and technical details.
- . provided a process for raising questions, answered each item in writing and made copies of all questions and answers available to all parties.
- . published the evaluation criteria and weighting factors so all contractors will know how the State will evaluate their proposals.
- . developed elaborate security procedures for conducting the evaluation and protected against the possibility of a change in evaluation criteria during the course of the evaluation.
- . formed an Executive Advisory Board composed of key departmental directors and deputies to oversee the procurement process and advise the Department on controversial issues.
- . invited representatives from the Legislative Analyst and the Federal government to all significant meetings as observers.
- . reviewed our activiites with various commissions and legislative committees.
- . met with various provider groups to explain our objectives.
- . hired various consultants to assist us in RFP preparation and evaluation.

- obtained legal counsel from the Office of the Attorney General throughout our effort.

- selected the "two step" procurement process, described below, for the fundamental reason that, in the final analysis, we will select a contractor who meets our requirements at the lowest submitted price.

The two step procurement process separates the technical evaluation and the price evaluation. The first step of such a procurement is composed of the issuance of an RFP by the State, the submission of a technical proposal by the proposer and the evaluation of the technical proposal by the State. The term technical has a broad connotation and includes both the system design and the proposer's willingness, plan, and ability to carry out the contract. No prices or pricing information are included in the technical proposal or the evaluation. The purpose of the first step in the evaluation will be to assure that proposals entering the second step provide the State with an acceptable level of service.

The technical evaluation of proposals will be conducted by the Medi-Cal Procurement Project with temporarily assigned staff from other State units. Team members and team leaders will be selected on the basis of procurement and program knowledge and experience from each program area or other area of operation as appropriate. There will be 11 teams of three evaluators each. The Medi-Cal Management Information System (MMIS) evaluation is divided into six subsystems with a separate team for each subsystem: S/URS, MARS, Provider, Reference, Recipient, and Claims Processing. The remaining administrative areas to be evaluated are divided into Data Processing with two teams, Corporate Capabilities with two teams and financial stability and bid price with one team.

The results of the evaluation analyses will be presented for review to the Technical and Price Evaluation Advisory Panel. This panel is composed of State managers from each State agency that is concerned with the operation of the Medi-Cal fiscal intermediary. Managers from the Department of Health, Department of Benefit Payments, Department of Finance, Department of General Services, State Controller, and Office the the Legislative Analyst have been asked to serve as panel memebers. In addition, a federal representative from the regional office of the Department of Health, Education, and Welfare has been invited as an observer.

The purpose of this panel is to provide critical review of the evaluation to insure that State and the Medi-Cal program management are aware of the technical strengths, weaknesses, and relative capabilities of the proposals, and to bring to the attention of the Project Director and the Executive Advisory Board any unresolved issues, considerations, or differences of viewpoint which should bear on the selection of the new fiscal intermediary.

The second step completes the process through the release of an Invitation for Bid by the State to those firms with acceptable technical proposals, the submission of a price proposal by the proposer, the evaluation of the price proposal by the State and the award to the lowest responsible bidder.

Our current status is as follows. Between four and six major corporations have expressed their intent to bid and all have committed substantial resources to bid preparation. The RFP was issued on schedule on October 3, 1977. The response date for technical proposals is February 1, 1978. We expect to complete technical evaluations by April 30, 1978; price evaluation by May 30, 1978; and have an approved contract by July 1, 1978. The contract will run for 5½ years from that date.

The procurement process has given rise to a number of controversial issues. We solicited written comments from all prospective bidders on their pros and cons. Issue memos were prepared by Project staff and presented to the Executive Advisory Board. This Board has ruled on all of these issues. The problem areas and the State's position are set out below.

State Ownership of the System

The State generally requires ownership of all Contractor deliverables. This precludes vendors from offering any systems in which they retain proprietary rights. The State's position has been formally protested by one vendor. The protest is currently being reviewed and the Department expects to make a ruling by Janaury 20, 1978.

Financial Risk

The State originally required that the Contractor be liable for all overpayments to medical providers caused by Contractor error. Concern was expressed that potential Contractor liability was virtually unbounded and that any given company's financial exposure was unacceptably large. The State modified its requirement so that Contractors are now liable up to 10% per year of their annual revenues under the contract.

COBOL Computer Language

The State requires that the entire data processing system be produced in the COBOL computer language (with several exceptions approved by the State Office of Data Processing Management). Several vendors wanted further relaxation of this requirement for technical reasons. We believe the State's interests in requiring COBOL outweigh the other considerations and have declined to relax the requirement.

Location of DP Center

The State requires that all operation tasks performed under the contract be conducted in California. One vendor requested to be allowed to locate its computer center outside the State. The Department declined believing that all jobs must remain in the State. If there is any workforce reallocation from the Bay Area, the Employment Development Department will establish special offices to provide assistance.

Two-Step Procurement

Objections to the two-step procurement process, previously described, have been two-fold. The basic thrust of the first contention is that the State will not get the best possible system. It is true that proposals receiving the highest number of evaluation points will not necessarily win. Lowest price is the final determinant. However, only those proposals that fully meet all of the State's requirements will have an opportunity to submit price bids. Therefore, whoever offers the lowest price will meet the State's needs. Because of the evaluation process that will be conducted, the Department does not agree with the contention that a "stripped down" proposal will necessarily be both acceptable and low price and therefore win. All bidders, with one exception, have fully endorsed this approach.

The second objection to the process is that it is illegal under California law. This issue is under formal protest and will be decided within the next three weeks.

Dental Program

California Dental Service (CDS) is currently under contract with the State to provide dental services to all Medi-Cal recipients on a capitation basis for all administrative and program dollar costs. As this pilot project was due to end on December 31, 1977, the Request for Proposals contains an option of including or excluding the processing of dental claims within the scope of work to be undertaken by the new Contractor. Proposers are directed to prepare this proposal in a manner which will allow the State to exercise its option of either including or excluding dental services within the contract.

The Department of Health is now conducting an evaluation of the California Dental Service pilot project as prescribed by statute. Based on the findings of this evaluation effort, a decision will be made as to whether to procure a separate contract on a capitation basis for the dental program or to include the dental program in the contract resulting from this RFP. The final decision is expected prior to the release of the Invitation for Bid (i.e., price proposals).

Checkwrite

Under the current contract, MIO prepares checks on their own check stock and performs the banking reconciliation functions through a subcontract with a commercial bank. The State audits each checkwrite to certify the accuracy and validity of the process and to monitor the size of the account balance to minimize the loss of State interest accumulation on the funds.

Under the new contract, the State Controller will receive a payment tape from the Contractor and will prepare and release warrants. The Contractor will retain all financial responsibilities with the exception of actually printing the payment documents and performing the reconciliation task.

The State Controller is the legal payor of State funds and ultimately responsible for their distribution. Concerns regarding fiscal accountability and the ability of the State to maximize its interest on the "float" and to eliminate bank service charges led the Controller to exercise his consititutional authority to issue warrants for payment of Medi-Cal claims. We are convinced that by working with the State Controller's Office, we can assure a smooth and timely reimbursement process for Medi-Cal providers.

IMPROVED CONTRACT MANAGEMENT

The Department of Health has developed a contract management plan which, coupled with the RFP, will provide the State with a means to become more involved in the daily operations of the fiscal intermediary. The Department has been criticized in the past for not being more active in monitoring fiscal intermediary operations. Beginning last year, the Department of Health established full-time on-site positions for State personnel to monitor the fiscal intermediary. Experience and knowledge of the fiscal intermediary system gained was the basis for an expansion of the monitoring activity under the new contract. In addition to assuring the integrity and propriety of fiscal intermediary activities, the contract management plan will allow the Department to gain the expertise necessary to eventually assume total operation of the Medi-Cal claims processing system.

The contract management plan also specifically addresses those portions of the RFP which will require ongoing review and monitoring for the purpose of assuring the adequacy of Contractor adherence to performance standards and other contractual terms and conditions.

THIRD PARTY LIABILITY

Currently, the fiscal intermediary pursues the collection of third party payments in instances of tort liability for an accident or injury. Under the new contract, the third party liability collection activity will be assumed by the State. This action is consistent with the recommendation of the Auditor General in an early 1977 report. This activity will be combined with the other health coverage collection efforts already performed by the State.

POST-PAYMENT REVIEW (S/URS)

The Surveillance and Utilization Review Section was established in fiscal year 1976 to promote a more extensive examination of provider patterns of practice for the purpose of identification of fraudulent and/or abusive practices. Currently, the State effort is focused solely on investigating referrals received from the fiscal intermediary, other State agencies, or the public. Under the new contract, system generated reports will permit analysis of the practice patterns of providers in relation to their peers. By utilizing the capability of the system to assimilate and compare data, personnel efforts in investigating potential problem providers will be more systematic, comprehensive, and productive.

PROVIDER CERTIFICATION AND ENROLLMENT

As a result of the RFP, the State will assume the responsibility for enrolling all new providers who wish to participate in the Medi-Cal program. The State will also be responsible for all modifications to the enrollment status of each provider and will input such information into the master provider file. The Contractor will maintain the integrity of the file, use the file in claims processing, and generate management reports based on file content. Currently, the master provider file is the responsibility of the Contractor. The State is seeking better control over the contents of this file and is planning to strengthen the enrollment and certification process by securing provider agreements from all participants in the program.

MEDICAL POLICY

Recognizing the need to become more active in the development and application of medical policy, the State will assume this responsibility under the new contract. Currently, both the State and the Contractor are involved in the development of medical policy. The RFP requires State approval of all policy applications prior to their use. This requirement, coupled with increased activity in reviewing the application of medical policy, will assure that the Contractor functions in a manner consistent with State policy. The experience gained by the State in this facet of fiscal intermediary operations will be beneficial should the State consider full operation of the system.

This concludes our comments. We will be happy to answer any questions you may have.

DEPARTMENT OF HEALTH, EDUCATION AND WELFARE

MEDICAID BUREAU

Health Care Financing Administration

THIRD PARTY LIABILITY

California State Assessment

October 1 - 17, 1978

Participants:	Bill Hirtz	(RO/Medicaid)
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THIRD PARTY LIABILITY

I. Background

Federal policy is that Medicaid should be the payer of last resort. Present regulations permit states to pay for medical services immediately; but when such payments are made require states to make all reasonable efforts to recover any monies that should have been paid by a health insurance company (42 CFR 433.135).

Some states, as policy, require providers to first bill an insurance company. If an insurance company does not pay the entire bill, the provider can bill Medicaid for the balance, but must show what was collected from the health insurance company.

Prior to 1972 California's general policy was to require providers to bill health insurance companies first. When California tried to enforce this system by withholding payments until third party resources were exhausted, many providers threatened to stop treating Medicaid beneficiaries.

In September 1972 a Department Task Force recommended changing the system so that the State would pay service providers, and assume responsibility to collect from health insurance companies. This system was implemented in October 1972.

About this time the Health Recovery Bureau was established to collect from insurance companies when an insured had medical services which could be paid from an insurance policy.

From October 1972 through May 1979, responsibility for making collections from liable third parties was shared. The Health Recovery Bureau made collections from health insurance companies for services given Medi-Cal beneficiaries. The Medi-Cal Intermediary Operations (MIO) was responsible for collections from liable third parties responsible for injuries or accidents involving Medi-Cal recipients. Starting June 1, 1979, the casualty insurance company collections will be made by the Health Recovery Bureau.

II. The Recovery Section System

A. Recovery from Health Insurance Companies:

The Recovery Section operates an automated system for billing health insurance companies which may be liable for the cost of medical services provided to Medi-Cal beneficiaries. This system for making collections from health insurance companies begins with the counties. During the initial interview to determine Medi-Cal eligibility, and all re-determinations thereafter, the counties collect information about health insurance policies from the prospective recipient. The counties and SSI send all eligibility information to the State to become part of the Medi-Cal Master Eligibility File. Counties send this eligibility information on all AFDC cases, and all Medical Assistance Only cases. SSA/SSI provides the same information on SSI cases and the SSI related cases where SSI determines eligibility under contract with the State. The Recovery Section maintains a computer file of Medi-Cal recipients who are known to have health insurance. Each month the Recovery Section compares its tape to the master eligibility file (CID file) to obtain the names of recent eligibles who have health insurance policies, or persons already eligible who have recently acquired health insurance. Also each month, the Recovery Section compares its computer file to the MIO paid claims tape to identify medical services performed for Medi-Cal recipients who have health insurance. Payment data is accumulated by recipient. On a quarterly basis, health insurance companies are billed as the cost of a recipient's medical services exceeds $100. Starting March 1979, this limit has been changed to $500.

Recovery Section Collections are the following:

Fiscal Year (Ending June 30)	Amount Collected
1973	$ 299,878
1974	1,125,755
1975	4,579,368
1976	2,524,102
1977	6,130,701
1978	10,131,847
TOTAL	$24,791,651

Recovery Section personnel stated that the average pay back is about 5 to 10 percent. In Recovery Staff opinion, it is not very cost effective to bill amounts less than $500.

The State has laws against the Medi-Cal program filing to recover medical expenses from recipients' estates. If there are survivors of any kind (relatives), filing for these expenses is not allowed. The State normally relies upon the County Eligibility Worker to inform them of the death of a recipient. In Los Angeles County the State will screen probate lists to determine the size of recipients' estates. The State recovered about $74,000 from probates last year.

The State can assess interest on unpaid liabilities from insurance companies but has not. Most insurance companies pay relatively quickly.

B. Assessment of the Health Insurance Recovery System

Federal financial participation is available when a state pays for services before determining the liability of a third party but makes reasonable effort to recover all monies that the third party should have paid. As a working definition of "reasonable effort to recover" we believe that all effort (staff and other resources) should be applied so long as this effort is cost effective. Stated another way, a state would be expected to invest some maximum amount of staff effort and other resources so long as monies recovered exceeded the amount spent to make the recovery. This concept was applied in assessing several parts of the TPL system.

1. Identification of Available Health Insurance

As noted in the brief systems description, the file starts with the county (for AFDC & MNO), or SSI (for adults) certifying the eligibility of an applicant. When an applicant has "Other Health Coverage", the information coming into the CID file is so annotated on the CID tape. When the Recovery Section file is updated monthly, all cases with a new indicator of Other Health Coverage have a computer developed letter prepared asking the recipient for complete information on the health insurance, such as: name of company, address of office servicing the policy, policy number, etc. When the recipient returns this information, the Recovery Section file is updated and insurance companies are billed as soon as the beneficiary receives medical services for which Medi-Cal has paid at least $500. When the beneficiary returns incomplete information or does not respond at all, there is one follow-up. If the recipient still does not give complete information or does not respond at all, further follow-up is discontinued (due to insufficient numbers of staff).

Recovery Section's experience under this sytem was that 5.1% of all applicants claimed some kind of "Other Health Insurance". After getting complete information (or trying to get complete information) on the companies, policy numbers, etc., only 26.2% of this group (or 1.34% of all applicants) would have sufficient information to permit billing an insurance company.

In 1978 the Recovery Section conducted a three county experiment to determine whether more effort at the time of application (or redetermination) would identify more persons with Health Insurance and/or produce more complete information on available heath insurance therewith enabling more bills to be sent. This project demonstrated that more effort at the beginning (with some increase in administrative costs) materially increased the identification of cases with Health Insurance, and substantially increased the number of cases where claims for service could be sent. Identification of potential "Other Health Coverage" was increased from 5.1% to 8.2%. Obtaining complete information on available insurance was increased from 26.2% of the cases to 69.7% of the cases. Expressed another way, billable insurance was increased from 1.3% of all applications to 5.7% of all applications.

The pilot project report estimated the cost effectiveness of implementing the increased emphasis of identifying recipients with health insurance on a statewide basis. With the expenditure of an additional $2.8 million, an estimated increase in collections to $16.6 million could be achieved.

Recommendation: Since it has been demonstrated that more effort at the beginning of the process identified more cases with potential "Other Health Coverage", and substantially increased the number of cases where sufficient information on existing policies is available so that claims can be sent to insurance companies, California should provide necessary additional funds, create the systems, and provide necessary training to install this system state wide.

If the normal budget system will not permit installation of an expanded "Other Health Recovery Identification System", perhaps a system could be installed with "seed money" to get the system started. Additional recoveries obtained under this system would both repay any monies advanced to start the system, pay the continued added cost of running the system, and in addition will produce an overall increase in recoveries.

In short, unless California invests some additional administrative money, both the State and the Federal governments are losing Medicaid dollars.

2. Staffing of Units Related to Health Insurance Collection Activities
DHS has not kept the units related to health insurance billing and collection activities fully staffed. In the 1977/78 fiscal year, the RS Unit was authorized 50 positions. The RS Unit was authorized an additional 11 positions for a total of 61 on July 1, 1978. Because of Proposition 13, the 11 positions were never filled. In addition, through the Governor's hiring freeze and attrition the Unit is now down to 38 people. Further, Health insurance billing and collection activity depends on computer programming support from the DHS central data unit. This unit is also understaffed with only 14 of 25 on hand and cannot hire replacements because of the freeze.

Because of the lack of staff several activities cannot be performed and several others must be delayed. These activities include:

i. Not following up when recipients do not return the insurance questionaire (HRB 2), or do not fully complete the form.
ii. Not reviewing claims returned by insurance companies or providing additional information when so requested by an insurance company.
iii. Not increasing collection activity.
iv. Not purging recipients' inactive health insurance records.
v. Not making insurance company site visits to insure that insurance companies are paying all they are supposed to.
vi. Not reconciling manual accounts receivable to an automated system.

Currently, the State is in the process of authorizing the staffing of the vacant positions. Since reduced follow-up will ultimately result in smaller collections, it is imperative that the State keep this activity and related support activities fully staffed.

Recommendations

1. DHS should insure that the Recovery Section be fully staffed and remain fully staffed in the future.

2. DHS should take the necessary steps to insure that computer programming support is adequate to meet the needs of Recovery Section.

3. Recovery Action After Payment of Bills

With respect to Third Party Liability, California operates in a dual mode. It encourages providers to first send claims to health insurance companies when a beneficiary has health insurance. Providers have done this, avoiding $41,000,000 in costs to the Medicaid program during calendar year 1978. The balance of services to beneficiaries with "Other Health Coverage" is paid by California and attempts then are made to recover program costs.

Considering staff shortages and the need to keep workload within the ability of staff to do the work, the Recovery Section recently raised the minimum amount of claims that would be billed to an insurance company from $100 to $500. This increase in the minimum level at which insurance companies could be billed was judged to materially reduce the amount of paper work in the billing process, and at the same time not significantly affect the amount of recoveries. However, choosing not to try to collect payment less than $500 could add up to substantial losses of federal and state funds.

Recommendations:

1. The State should determine how much money is not being billed because of the minimum of $500 before a claim is submitted to an insurance company. By applying the historical experience of 10 percent collections, a reasonable estimate of potential dollars lost could be developed.

2. If the estimated dollar losses are substantial, one of several options should be considered.
    a. Adopt a policy requiring providers to bill insurance companies first, and only billing Medicaid for any additional monies due.

    b. As a less desirable option, continue the practice of encouraging providers to first bill insurance companies, pay the bill and then attempt to collect; but, reducing the State billing level to $50, or a level where cost effectiveness can be demonstrated.

The first of these recommendations would clearly cause insurance companies to shoulder the maximum amount for which they are liable. (Costs to the State would be correspondingly less.) Implementing the first recommendation would also be consistent with Department of Health Services' efforts to restructure the Medi-Cal program. Providers who elect to participate in the program would be required to first bill insurance carriers when a recipient has health insurance. Additional front end work (Recommendation 1) would further aid this process.

III. Recoveries from Casualty Cases

A. Background

The Medi-Cal Intermediary Operations (MIO) is responsible for the Third Party Liability (TPL) effort for injury or accident cases. The State plans to take over all TPL responsibility in June 1979. The MIO has budgeted for TPL operations through December, 1979.

During the MIO checkwrite function, claims exceeding $50 with certain diagnosis codes, listed in the International Classification of Diseases Adapted (ICDA) - 8th Edition, which are most likely to be TPL related are identified and added to the "Suspected TPL Case File". MIO figures show a total of 258,830 new cases (claims) added to the "Suspected TPL Case File" during the nine months ended September 30, 1978.

When a case is added to the "Suspected TPL Case File", the computer automatically generates a letter which is sent to the beneficiary. The letter requests that the beneficiary give certain information pertinent to his case which would assist the MIO in deciding whether the case has potential for recovery or not.

Sixty days from the issuance of the first letter, a second letter is automatically generated and sent to those beneficiaries who have not responded to the first letter. However, second letters are only sent on paid claims of $200 or more. This letter again requests the beneficiary to write or call MIO's toll free number to give particulars about the claim. If there is no response to either letter, the case remains in the "Suspected TPL Case File".

Many potential TPL cases are identified from other sources such as attorneys, county welfare departments and beneficiaries. Depending on potential dollar recovery, first and second letters are sent to the appropriate parties, and the data is entered into the "Suspected TPL Case File".

If MIO determines through contact with appropriate parties that a case has no recovery potential, the case is deleted from the "Suspected TPL Case File" and closed. Though reasons for closing cases vary, generally, cases are closed in those situations where liability cannot be assessed, or in those situations where a liable third party does not have insurance or resources sufficient to cover the cost of medical care. MIO reports show that a total of 107,360 cases were closed during the nine months ended September 30, 1978, because there was no potential for recovery.

All cases for which MIO obtains sufficient information to determine that there is potential for recovery from a third party are entered into the "Accounts Receivable File." During the nine months ended September 30, 1978, MIO added a total of 14,969 new cases to the Accounts Receivable File. These cases included 9,085 from the "Suspected TPL Case File" and 5,884 from sources other than the claims processing system.

For cases on the "Accounts Receivable File", MIO personnel research the appropriate beneficiary claim history files to obtain information on all claims related to the case, send letters to appropriate attorneys, insurance companies, etc., monitor recovery action and close cases as appropriate. Cases for which liable third parties do not make payments are referred to the State for further action.

During the 9 months ended September 30, 1978, MIO closed 5,836 cases from the Accounts Receivable File. No recoveries were made for 2,239 ($5,183,700 of claims paid) and recoveries were made for 3,597 ($4,535,700 of claims paid).

B. Summary Statistics for 9 Month Period Ended September 30, 1978

Accounts Receivable January 1, 1978	-	$35,021,500
Amount recovered and written off	-	(4,535,700)
Amount unrecovered and written off	-	(5,183,700)
Accounts Receivable amounts added		20,120,100
Accounts Receivable September 30, 1978		$45,422,200

C. HEW Audit Agency Report

The HEW Audit Agency issued a report (No. 60204-09) dated February 27, 1976, which evaluated MIO's procedures for making collections from liable third parties. The report made recommendations concerning most aspects of MIO's operations. The reported problem areas included (i) accountability for claims referred to and reviewed by case analysts, (ii) timeliness of notification of third parties of their liability, (iii) effectiveness of collection efforts, (iv) effectiveness of controls over case closures, and (v) effectiveness of internal controls over cash receipts. Since the State plans to assume MIO's responsibilities for collections in the future, we did not make detailed follow-up reviews of each of the Audit Agency's recommendations. However, our limited review of MIO's current procedures indicated that substantial improvements had been made in all aspects of MIO's third party collection activities since the Audit Agency's review.

D. Findings and Recommendations

Since effective June 1979 the Recovery Section is taking over from MIO the responsibility for making casualty case collections, we have limited our recommendations to those areas which will affect future operations.

Use of Diagnosis Codes

MIO currently uses a file of diagnosis codes against which paid claims are matched to determine potential third party recoveries. No studies have been made to determine if the use of individual codes results in recoveries or a great deal of paperwork for MIO with no pay off. In addition, no data has been developed to show if TPL cases from other sources, which accounted for 39 percent of new cases added to the Accounts Receivable File during the nine months ended September 30, 1978, contain a certain group of diagnoses which are not in the current file of codes used. Many cases may not be identified that could be if certain diagnosis codes were added to the file. The State currently relies on individuals other than the beneficiary or provider to be responsible enough to inform the MIO of potential for recoveries.

Recommendation

DHS should perform two studies; one, to determine the pay-off from the diagnosis codes in the current file and delete those that are not productive; and, two, to determine if any additional diagnosis codes should be added to the file.

REGION IX

DEPARTMENT OF HEALTH, EDUCATION AND WELFARE

HEALTH CARE FINANCING ADMINISTRATION

MEDICAID BUREAU

Long Term Care

CALIFORNIA STATE ASSESSMENT

November 6-17, 1978

Participants: Jean Hoodwin (RO/Medicaid)
Carol Goodman (RO/Medicaid)
Frances Contreras (RO/Medicaid)
Delores Booker (RO/Medicaid)
Ellen Macdonald (RO/HSQB)

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Executive Summary

California provides the full range of long term care services in general SNFs and ICFs and in specialized facilities for developmentally disabled and mentally disabled individuals. Home Health Agency services and Adult Day Health Care Centers complete the State's LTC program.

Despite the potential for a well-rounded LTC program, there is a severe imbalance between SNF and ICF beds and underutilization of HHCS. Delays in adopting State regulations for ICFs/DD have hindered the development of appropriate care for this group.

Since the State wants to move toward greater utilization of community based programs and transfer of patients out of large State institutions into community facilities that provide high quality services, active participation by Medi-Cal in developing alternate types of care, as was done in ADHCC, is essential.

LONG TERM CARE

Background

For Medi-Cal recipients, long term care includes the traditional modes of service in SNFs, ICFs and home health agencies (HHAs). In addition to general SNFs and ICFs, the State provides specialized services in SNFs for the developmentally disabled and the mentally disabled. A newer form of long term care is developing in Adult Day Health Care Centers (ADHCCs). This program was encouraged by the State Agency through funding with a Federal demonstration grant during the past four years. The program is designed to keep chronically ill people living in the community with supportive services. Effective, July 1, 1978, ADHCC services were incorporated into the Medi-Cal program, and the State is encouraging their development throughout California.

Approximately 20 percent of the Medi-Cal budget is spent on the SNF, ICF and HHA segments of long term care. This percentage however, does not reflect drug expenditures for patients in long term care facilities nor services of practitioners who treat patients in the facilities, but who are reimbursed directly by the State agency rather than included in facility costs. Total expenditures for long term care probably represent 30 or 35 percent of the Medi-Cal budget.

During FY78, Medi-Cal had provider agreements with 1170 SNFs, 312 of which also have some certified ICF beds, 36 free standing ICFs, and 130 HHAs. The table below for FY75 through FY78 shows the number of recipients who received SNF, ICF and HHA services, and the payments made.

Payments for Medi-Cal Recipients
to SNFs, ICFs and HHAs FY75-78

Fiscal	SNF		ICF		HHA	
Year	Recipients	Payments*	Recipients	Payments*	Recipients	Payments*
1978	126,260	$523.4	8,380	$24.9	11,240	$2.4
1977	122,434	414.8	9,027	21.7	12,354	2.4
1976	149,160	377.1	25,336	49.7	11,954	1.8
1975	119,972	348.8	10,478	20.6	14,362	2.2

*Payments in millions

In 1978 SNF payments represented approximately 22.6 percent of the Medi-Cal budget while one percent was expended for ICF services. During the same period 1/10 of one percent was expended for home health agency services. The sharp increase in the number of ICF patients and payments in FY76 and the corresponding marked decrease in ICF patients and payments in FY77 reflect the State's initial attempt to implement Federal requirements for developing alternate levels of long term care and the nursing home industry's response. In FY76, State ICF regulations were developed to provide long term care at lower cost for recipients who did not require the kinds of services provided in SNFs. The reimbursement differential between SNFs and ICFs was 20 percent. Although a small number of free standing ICFs and many ICF beds within SNFs were certified in FY76, the industry became increasingly dissatisfied with the reimbursement, and many ICF beds were terminated. The facilities either closed down their ICF units or requested that the beds be certfied for SNF care.

SNF patients constitute 87 percent of the total in LTC facilities Of the 182 licensed home health agencies in the State, 130 are certified for participation in Medi-Cal. The newest service in the Medi-Cal program, ADHCCs, an alternative to SNFs and ICFs, was added in July 1978 after four years as a demonstration project.

Administrative responsibility for Medi-Cal LTC services is shared by several units within State government. Primary responsibility resides in the Department of Health Services (DHS), but as the organization chart (attached as appendix 1) shows, LTC functions are dispersed among three Divisions in DHS and in the Departments of Developmental Disabilities and Mental Health. The latter two Departments cooperate with DHS in working out arrangements for provision of care to Medi-Cal recipients by institutions and clinics under their jurisdiction.

Regulations for LTC services are prepared by the Policy Analysis Section with consultation from Medical Policy and Standards, Pilot Projects Section, Mental Disabilities Services Branch and Developmental Disabilities. Policy is transmitted through Field Services Section to 12 Field Offices (FOs) responsible for prior authorizing all LTC. (See Utilization Review section for description of FO organization and functions.)

In the FOs visited (Sacramento, San Francisco, San Jose), there was a uniform understanding of LTC policies and procedures. Level of care decisions are based on professional judgment and various mechanisms are used to guide FO staffs. These include:

1. State regulations in Title 22
2. Medical review procedures manual (has not been updated since 1972)
3. Monthly field administrators' meetings
4. Periodic meetings for chief Medical Consultants
5. A memorandum system which includes: a) Medi-Cal bulletins, b) Operating Instructions Letters, c) Field Instructions Notices, and d) MBS policy statements.
6. Informal phone conversations with other Field Offices. (All FOs visited cited this as an effective means for clarifying policy.)

Written level of care criteria would help to assure that patient placements are based on common standards.

Finding; LTC Bed Shortage

Almost all FO's, as well as the Central Office staff, commented on the shortage of LTC beds. San Diego, San Bernardino, Santa Barbara, Fresno, San Francisco and Shasta were cited as examples of counties with acute shortages. Although ICF bed availability is particularly critical, all FO's, except for Los Angeles and San Jose, have also reported a shortage of SNF beds. San Jose has a "delicate balance" as, to date, all patients have been placed, but the occupancy rate is almost to its limit. The San Jose FO coordinates bed availability information for all facilities under its jurisdiction through weekly phone calls to all SNFs and ICFs for a count of available beds. Despite the time required for these calls, the staff considers them an effective way to monitor bed occupancy and to facilitate movement of patients in and out of facilities.

State staff believe LTC bed availability is tied to the Office of Statewide Health Planning responsibility for assuring that, statewide, there is an adequate number of beds, but no over-bedding, at different levels of care (hospitals, SNFs, ICFs). New facilities may not be built or old facilities expanded without a certificate of need issued by the Office of Statewide Health Planning. Under State law, facilities must be operating at 90 percent of capacity before a certificate of need can be issued. There is a difference of opinion on how much influence State agencies have on decisions concerning health facility expansion. Medi-Cal Central Office staff believe the State Agency can do little to influence these decisions. Sacramento FO staff, having had experience in working with the local Health Systems Agency, has, however, been able to bring HSA's attention the need for increased facility resources in the area.

Recommendation

Medi-Cal Central Office should encourage and facilitate throughout the State the kind of partnership between HSA and the FOs that has developed in Sacramento with FO staff documenting needs and working with HSA to meet the community's health facilities needs.

Finding: Intermediate Care Facility Beds

There is agreement throughout the State that the greatest LTC need at present is for ICF beds. Although ICF bed availability increased between 1975 and 1976, there was a sharp drop in bed capacity in 1977 and 1978. The lower reimbursement for ICF care is not attractive to providers who, while not required to have skilled nursing services available in ICFs seven days a week, must provide equally costly services and programming to meet patients' needs.

The imbalance between SNF and ICF beds may be resolved when the State implements regulations on cost related reimbursement of long term care facilities, but it is likely that the loss of ICF beds will not be overcome without action by the State Agency to encourage providers to increase the number of ICF beds.

An example of this imbalance was found in the San Francisco Field Office which covers San Francisco, San Mateo and Marin, where 60 SNFs served between 3700 and 4000 Medi-Cal patients in FY78. The area has no ICF beds. The acute need for long-term care beds was demonstrated in the 1978 crisis related to the San Francisco Convalescent Facility, a SNF that was decertified after many months of struggle between the State and the facility. Placements had to be found for 124 patients. Only 39 patients were placed in San Francisco SNFs. Placements were located in San Mateo for 47 patients, 11 went to the East Bay area and 5 to Santa Rosa. Five went home and the rest went to acute care hospitals, board and care homes or other types of care. This was an unusual situation that required the movement of a large number of patients who were primarily San Francisco residents throughout and beyond the three-county area, but it was traumatizing to patients and families.

From a review of FY78 statistics of the Sacramento FO Medical Review Team actions, it appears that level of care decisions are influenced by the limited availability of ICF beds Annual reviews were done on 3,565 SNF and 275 ICF patients. Level of care changes were recommended in four percent of the cases. The statistics reflect a significant difference between numbers of SNF and ICF beds and raise the question of the extent to which Medical Review team decisions are influenced by the reality of the severe limitation of ICF beds.

Recommendations

1. Specific level of care criteria should be developed by Medi-Cal Central Office to guide FO staff in determining appropriate patient placement.

2. Medi-Cal should review ICF reimbursement rates to assure that they are cost related, and can stimulate the supply of ICF beds.

3. Medi-Cal should encourage the development of additional ICF beds through discussion of the issues with provider organizations and other groups concerned with long term care.

Finding: Intermediate Care Facilities for the Mentally Retarded

From the beginning of the Medi-Cal program the State has classified institutions for the mentally retarded as SNFs. (The State uses the term Skilled Nursing Facilities for the Developmentally Disabled -- SNF/DD.) When Federal regulations covering Intermediate Care Facilities for the Mentally Retarded (ICFs/MR) were finalized in 1974 and standards developed for these facilities, it was intended that states would reclassify mentally retarded patients in long-term care facilities and survey the facilities under ICF/MR regulations. (State terminology is ICF/DD.) Development of State regulations and reclassification of patients under those regulations was not completed until 1978. Most facilities have been surveyed under ICF/DD regulations and the State expects to have all such facilities (approximately 30) surveyed by March 1979.

Although the surveys are close to completion, the facilities remain classified as SNFs because the State's reimbursement regulations for this level of care have not been adopted. Facilities classified as SNFs/DD are being reimbursed between $32.31 and $34.93 per day depending on bed capacity. Reimbursement includes a supplemental payment of $4.54 per day for special DD program services. These figures are below staff estimates for ICF/DD reimbursement which would range from $35.00 to $41.00 per day. The delay in increasing reimbursement to provide ICF/DD services has impeded facilities' compliance with staffing requirements and is delaying implementation of ICF/DD programming.

Since the Legislature has already appropriated funds to begin building changes required to meet ICF/DD standards in State facilities, the delay in increasing per diem payment needed to fund programs adequately could negate efforts made by the State over the past few years to provide an effective treatment program for the developmentally disabled.

Recommendation

Issues delaying adoption of higher reimbursement levels for ICF/DD services should be resolved and the State's regulations finalized so that programs can begin to function with adequate staffing.

Finding: Home Health Care Services (HHCS)

Limitation of Services

Out of 182 home health agencies in the State, 130 had Medi-Cal provider agreements, but only 97 HHAs served Medi-Cal patients during FY78 Although payments for HHCS almost doubled between 1972 and 1978, increasing from $1.3 million to $2.4 million, the number of Medi-Cal patients who received these services decreased 16.5 percent during the same period. Out of 3.4 million recipients in FY78 there were 134 640 individuals in SNFs or ICFs, and 11,240 received HHCS. It would appear that HHCS, as an alternative to inpatient care in LTC facilities, is underutilized.

Medi-Cal regulations in Title 22 Section 51125, define home health services as skilled nursing service and at least one therapeutic service such as physical, occupation or speech therapy. This is contrary to Federal regulations under 42CFR440.70 which do not make the receipt of physical, occupational or speech therapy at home dependent upon the provision of skilled nursing services. State staff acknowledged that they had misinterpreted Federal regulations, but thought the rewrite of regulations published in the Federal Register on September 29, 1978 clarified the requirements, and they plan to revise State regulations. A letter was sent to the State Agency on 12-18-78 to reinforce the need for revision of the State regulations and reinterpretation to providers and recipients of the availability of HHCS.

Recommendation

State regulations must be revised so that HHCS are provided to individuals in need of this type of care without being restricted to those who need skilled nursing services.

HHCS - Problems in Implementation

Although relationships between HHAs and Medi-Cal have improved in the past year, Home Health Agency representatives cited continuing problems of low reimbursement, cumbersome administrative procedures, poor understanding of the components of HHCS by Medi-Cal consultants and inconsistency in interpretations of Medi-Cal policy by consultants in different field offices. The following are illustrative of issues raised·

1. Although 13 percent of patients served by the San Francisco VNA is on Medi-Cal, the agency receives only six percent of its revenue from Medi-Cal. Medi-Cal payment is less than cost, as the State pays less than 50 percent of the costs of a home health aide visit and 2/3 of the cost of an RN visit.

2. The type and extent of information required from HHAs on the TAR varies among the FOs. There are no written instructions relating to completion of TARs.

3. There are variations among Medical Consultants in authorizing services and a lack of understanding of roles of physical therapists and occupational therapists. There are no written guidelines for services covered under HHCS.

4. Authorization and billing procedures result in time loss for both the HHA and recipients.

Recommendations

1. Medi-Cal Central Office staff should meet with representatives of HHAs to consider and resolve coverage, reimbursement and systems issues.

2. Communication between Medi-Cal and HHAs should extend to the FOs so that uniform policies and interpretations related to HHCS are provided by all FOs.

HHCS - Statewideness

Potentially, State regulations which limit providers of HHCS to Home Health Agencies could preclude eligible individuals in certain counties from receiving HHCS. According to Medi-Cal staff Home Health agencies serve the entire State, but a State statistical report for January June 1978 shows that no recipients in eight counties received HHCS during that period. The counties were Alpine, Amador Del Norte Kings, Mariposa Modoc Plumas, and Sierra. Considering the small population in those counties, it is possible that no recipient needed this service during that six-month period.

Recommendation

The State should review the availability of HHCS on a Statewide basis. If it is found that some counties or population centers are not covered by home health agencies, some mechanism must be worked out to make these services available. Under Federal regulations, home health services are not dependent upon the availability of home health agencies.

Finding: Adult Day Health Care Centers (ADHCCs)

State Legislation, AB1611, established, effective July 1, 1978, ADHCC as facilities to provide health services, activities, and recreation to maintain individuals in the community and to prevent placement in SNFs or ICFs. The centers are licensed as clinics and are certified under the Medi-Cal program. At the time of the LTC assessment in November 1978, Medi-Cal had certified five ADHCCs, which included nine centers located in three cities, San Francisco, Sacramento and San Diego. Fourteen other counties were planning to establish ADHCCs. The legislation mandated a planning council in each county which must submit a plan for developing centers.

Among the services provided in these centers are nursing, personal care, psychosocial services, physical, occupational and speech therapy, consultant physician, transportation and special services. Reimbursement for the full package of services has been set at $24.00 per day. $18.46 has been established as the base rate with adders for special services which include the consultant physician, transportation and meals.

Centers are expected to serve a minimum of 30 participants who may be either Medi-Cal recipients or from the private sector. Although the centers can serve individuals 21 years of age and over, the age range currently served is between 55 and 98. From a sample of records reviewed the diagnoses do not differ significantly from those found among patients in SNFs and ICFs. However, the physical and mental condition of indivdiuals observed during visits to four centers showed the participants to be more alert and functioning at a higher level of competency than SNF or ICF patients.

Prior to acceptance in a center, an individual comes to the center for a 3-day assessment. ADHCC staff believe a longer assessment period--perhaps two weeks--is necessary in order to evaluate participants and to identify problems that would make day care placement inappropriate. Individuals attend the ADHCC between two and five days a week and although some participants move into more independent functioning in the community and eventually out of the center most are expected to remain as long term participants in the ADHCC program.

Staff of the San Diego centers include a program director, licensed vocational nurse, activities coordinator, crafts-person, part-time aides and part-time physical, occupational and speech therapy consultants. Each center also gets three hours of psychiatric consultation per month and four hours consultation per month each from a pharmacist and a dietitian.

Special features of the ADHCC program include home visits to evaluate the individual's functional capacity in the home setting, family night once a month when families come to the center to socialize and discuss topics of mutual interest, and participation of community groups in the centers' program.

Recommendations

1. Medi-Cal should reexamine its policies on the three-day limit for the initial assessment and on payment for assessment. At present, if an individual is not recommended for acceptance after the initial evaluation, the center is not reimbursed by Medi-Cal for assessment.

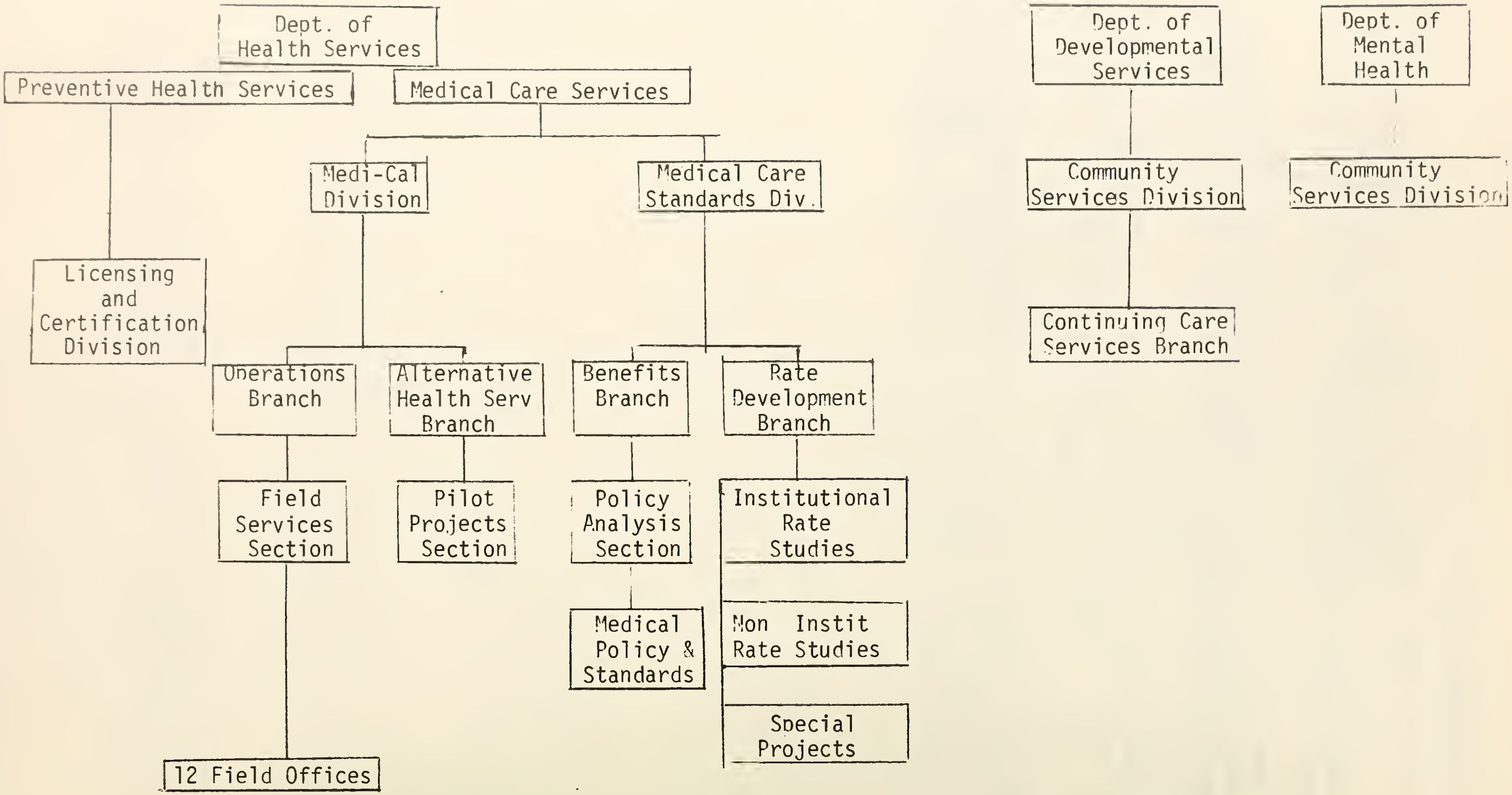
2. Since ADHCC activities are comprised of a mix of medical, health-related, social and recreational services, there should be further assessment of the nature of these centers as additional ADHCCs come into the program.

3. Since there are no established criteria for Medical Consultants to use in determining which Medi-Cal recipients should be placed in ADHCCs, criteria should be developed that will assist FO staffs in knowing when to refer individuals to ADHCCs.

4. Medi-Cal has developed a series of detailed Adult Day Health Care Centers Procedures letters which are sent to ADHCC Directors to assist them in obtaining Medi-Cal authorization for ADHCC services and in developing a record system for the centers. Although pro cedures have been discussed with FO staff, similar materials should go to FOs explaining the ADHCC program.

Appendix

ADMINISTRATION - MEDI-CAL LTC SERVICES


Dept. of Health Services
Preventive Health Services
Medical Care Services
Licensing and Certification Division
Medi-Cal Division
Medical Care Standards Div.
Operations Branch
Alternative Health Serv Branch
Benefits Branch
Rate Development Branch
Field Services Section
Pilot Projects Section
Policy Analysis Section
Institutional Rate Studies
Medical Policy & Standards
Non Instit Rate Studies
Special Projects
12 Field Offices
Dept. of Developmental Services
Community Services Division
Continuing Care Services Branch
Dept. of Mental Health
Community Services Division

REGION IX

DEPARTMENT OF HEALTH, EDUCATION AND WELFARE

HEALTH CARE FINANCING ADMINISTRATION

MEDICAID BUREAU

Family Planning

CALIFORNIA STATE ASSESSMENT

February 19-March 1, 1979

Participants: Henry F. Tyson (RO/Medicaid)

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FAMILY PLANNING, STERILIZATION AND ABORTION SERVICES

I. Introduction

Since the inception of California's Medicaid program in 1966, family planning services have become an increasingly important component of the State's program. Federally funded family planning services are those which are voluntarily requested by a Medicaid recipient for the sole purpose of limiting family size. The offering of these services to all Medicaid recipients is required under current provisions of the Title XIX (Medicaid) program. Family planning services are, in addition, eligible for increased Federal financial participation (FFP), i.e., they receive 90% FFP.

The Department of Health Services' (DHS) Office of Family Planning has the primary responsibility for the formulation of family planning program policy. In addition to the Medicaid program, these policies govern other Federally funded programs providing for family planning services, including Title X of the Pubic Health Service Act and Title XX of the Social Security Act, as well as services funded only by the State. The Medical Care Standards Division of the Department of Health Services is responsible for developing Medicaid program regulations and administrative procedures that comply with Federal Medicaid requirements.

Although sterilization and abortion are sometimes considered family planning services, since they can be performed for reasons other than family planning, both are subject to special prohibitions under the Medicaid program. Currently, the Department of Health Services offers both services as a family planning program benefit, though abortions performed for family planning purposes do not receive Federal funding.

II. Family Planning

Background

From 1968 to 1972, the Department of Health's Bureau of Maternal and Child Health had the primary responsibility for developing and establishing State policies and standards for family planning services. These policies governed all family planning services funded under the State's Medicaid program as well as those services funded by other Federal and State programs. In 1972, the State created the Office of Family Planning which assumed all responsibility for the formulation of family planning policy.

In addition to the Office of Family Planning, the Medical Care Standards Division is responsible for developing State Medicaid program policies on family planning. The Benefits Branch of this Division is responsible for developing Medicaid program regulations and procedures on family planning, and the Rate Development Branch is responsible for setting provider reimbursement rates for family planning services provided to Medicaid recipients.

The State currently has approximately 1075 licensed hospital outpatient and other clinics which have the capability of providing family planning services to Medicaid recipients. 135 of these clinics are recognized by the State as Community Family Planning Centers and, in addition to Medicaid, receive funding under Title X of the Public Health Service Act and Title XX (Social Services) of the Social Security Act. Family Planning services provided at these clinics include:

1) Physician Examinations and Laboratory Services
2) Venereal Disease Services
3) Contraception Information and Devices
4) Sterilization Services
5) Information and Education - with special emphasis on Teen Outreach
6) Pregnancy Testing
7) Referral and Follow-up
8) Transportation (if necessary)

DHS standards for providing these services are contained in the Office of Family Planning publication "Guide Book for Family Planning Services" and State Medicaid program regulations (Title 22, 51305.1 - 51305.8) on sterilization.

Federal funding under the State's Medicaid program is generally available for most family planning services given at the direction of a physician. Other services such as counseling, infertility care, abortion counseling and special teenage pregnancy outreach are not covered services, but are usually available to Medicaid recipients under other Federal and State programs.

DHS does not require Medicaid recipients to give their signed consent for family planning services, though "informed consent" is required for all sterilization procedures and consent for services provided by other Federal and State programs is also required. The State considers all sexually active persons under the age of 21 as potential "school age parents" and does not require parental consent from them for family planning services. Finally, all family planning services provided to Medicaid recipients are considered confidential and preclude the sending of an "Explanation of Benefits" to the recipient's home.

Findings

1. DHS has a very comprehensive and well managed family planning program. State practices in the offering of family planning services to Medicaid recipients are considered exemplary.

2. DHS's current system for the identification and documentation of family planning services eligible for 90% FFP is considered weak. The State heavily relies upon the discretion of health care service providers and their fiscal intermediary to correctly identify those medical services which are for the sole purpose of limiting family size, without the routine review and monitoring of the accuracy of those determinations.

   In May of 1978, DHS submitted a proposed "Family Planning Reporting System" to the Medicaid Bureau as a means for accurately identifying and supporting all claims for family planning and 90% FFP. The Medicaid Bureau reviewed the proposed system and, with only a few modifications and a cost feasibility study, enthusiastically endorsed the system for implementation. DHS has agreed to make whatever modifications are necessary to the proposed system and to submit for review and approval a cost feasibility study to the Medicaid Bureau. The State projected that the system would be fully implemented by no later than June 30, 1979.

   ### Recommendation

   DHS must, at the earliest possible date, complete the implementation of its proposed or an alternate reporting system to support all claims for family planning expenditures and 90% FFP.

III. Sterilization

Background

Under Medicaid regulations (45 CFR 205.35), Federal funding of sterilizations is available only after the Medicaid recipient has voluntarily requested to be sterilized and given his or her "informed consent". In addition, the recipient must be advised that he or she can decide at anytime to withdraw their consent to be sterilized without affecting any program benefits they receive, the sterilization cannot be performed in less than 72 hours after informed consent is given, and the recipient must be a mentally competent individual of 21 years of age or older.

On November 8, 1978, the Department of Health, Education and Welfare issued new regulations (42 CFR 441.250 - 441.259) effective March 8, 1979, governing sterilizations. Under these regulations, States are required to adopt a Federally designed informed consent form containing all of the elements of "informed consent". Although most other requirements for sterilization remained the same, some important changes were made:

1) the waiting period was extended from 72 hours to 30 days;
2) hysterectomies were prohibited as a sterilization procedure for family planning purposes; and
3) recipients of sterilization are required to be given orally all required information necessary to give their informed consent for the procedure.

Findings

3. DHS requested an extension of the effective date for implementation of the November 8, 1978 regulations. DHS contended that the extension was administratively necessary for the State to 1) obtain the large number of optional informational pamphlets and required "informed consent" forms for distribution, 2) distribute the pamphlets and "informed consent" forms to all providers, and 3) publish State regulations requiring all providers to adopt the new pamphlets and "informed consent" forms. This request for an extension was denied by HEW.

   ### Recommendation

   DHS must take whatever steps are necessary to implement those requirements before claiming Federal financial participation for sterilization.

4. DHS has given instructions to its fiscal intermediary (Medi-Cal

Intermediary Operations - MIO) not to reimburse any provider claim for sterilization unless: 1) a legally executed "informed consent" form accompanies the claim, 2) the sterilization was not performed sooner than 72 hours after informed consent was given, and 3) the recipient was at least 18 years of age. The State's practice of providing sterilizations to persons between the ages of 18 and 21 is clearly prohibited under Federal regulations for purposes of FFP.

Recommendation

DHS must assure that sterilization of persons between the ages of 18 and 21 are identified and do not receive FFP.

5. Importantly, it was found that DHS has not routinely reviewed their intermediary operations to assure that all procedures are being conducted in a manner consistent with Federal regulations.

Recommendation

DHS must review its fiscal intermediary operations on a regular basis to assure that all Federal requirements (42 CFR 441.250 - 441.259) on sterilization are being met.

IV. Abortion

Background

Before August 5, 1977, the Department of Health, Education, and Welfare would provide Federal financial participation for all abortions. Federal matching of State expenditures was available at 90% FFP for abortions performed for family planning purposes and 50% FFP for all others.

On August 5, 1977, the so-called Hyde Amendment to the DHEW Appropriations Act for FY '77 became effective and prohibited FFP for all abortions except those which were considered necessary to save the life of the mother. However, on December 1, 1977, the DHEW Appropriations Act for FY '78 expanded the number of exceptions to the prohibition of expenditures for abortion to include:

1. those instances where severe and long lasting physical health damage would result if the fetus were carried to term, when determined by two physicians,
2. those instances where the person was a victim of rape or incest, when such an incident is promptly reported to a law enforcement or public health agency as well as,
3. those instances where the life of the mother would be endangered if the fetus were carried to term (see 42 CFR 441.200 - 441.208).

Despite the prohibition of Federal funding of abortions except under the above circumstances, DHS has continued to provide abortion services to all Medicaid recipients with State funds. This policy was significantly altered by newly enacted State law (AB 2190), which sharply limited the circumstances under which abortions performed after August 15, 1978 would have been paid for by the State. However, as a result of a State court injunction, DHS has been required to continue providing abortion services to all Medicaid recipients desiring them until such a time as the court determines otherwise.

Findings

6. Since August 5, 1977, when the Hyde Amendment became effective, DHS has failed to separate and thereby identify abortions expenditures, on a quarterly basis, from other medical expenditures. As a result, DHS has based its claims for FFP on an estimate of the abortion expenditures.

Recommendation

DHS must take whatever action is necessary to separate abortion expenditures from all other medical expenditures.

7. DHS has not developed the administrative procedures necessary to identify those abortion claims which would be eligible for FFP. Federal regulations (42 CFR 441.200 - 441.208) require that the State agency must have received all necessary physician certifications and other documentation before reimbursing any Federally allowable abortion claim.

   As a result of the State's inability to accurately identify family planning and abortion expenditures with required supporting data, the Medicaid Bureau has undertaken a financial review of all California expenditures for family planning and abortion.

   Recommendation

   DHS must develop and implement procedures to identify and document any Federally reimbursable abortion claim.

REGION IX
DEPARTMENT OF HEALTH, EDUCATION AND WELFARE
HEALTH CARE FINANCING ADMINISTRATION
MEDICAID BUREAU

Prepaid Health Plans/Health Maintenance Organizations

CALIFORNIA STATE ASSESSMENT

November 6-17, December 4-8, 1978

Participants: Charlotte Harrington (RO/Medicaid)
Dub Johnson (RO/Medicaid)
Leonardo Coard-LaBarrie (RO/Medicaid)
Neil Merino (RO/Program Integrity)
Nancy McMahon (CO/Medicaid)

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EXECUTIVE SUMMARY

California has been in the forefront of experimentation with Medicaid contracting with PHPs/HMOs. The State currently contracts with 13 organizations and expects 2 additional contractors in early 1979. The State has developed the most sophisticated PHP monitoring and technical assistance system in the country. For the most part, the State has resolved the major problems that existed in this program in the early 1970's.

There are several areas still in need of improvement. These areas include coordination with the State Department of Corporations, subcontract review, control of potential duplicate payments, and State audit and follow-up. The Department of Health Services is making progress toward streamlining the operation of the program.

Prepaid Health Plans - Health Maintenance Organizations

Background

California Department of Health Services (DHS) currently has 13 contractors that provide Medi-Cal services on a prepaid capitation basis. Eight of these organizations are qualified Health Maintenance Organizations (HMOs) and are listed below with their qualification dates:

California Medical Group Health Plan (CMGHP)	7/19/77
Family Health Services, Inc. (FHS)	12/14/76
Health Alliance of Northern California (HANC)	11/29/76
Family Health Program (FHP)	7/29/77
Kaiser Foundation Health Plan, Inc. - South	9/9/77
Maxi-Care	3/25/76
Northern California Institute for Medical Services (Rockridge)	3/17/78
South Los Angeles Community Health Plan (SLACHP)	2/10/78

Three of the 13, Watts Health Foundation, Family Health Foundation of Alviso, and Northeast Valley Health Corporation (NEVHC), are exempt from qualification based on their status as Section 319 or 330 grantees of the Public Health Service. Watts and NEVHC have applied for HMO qualification despite this exempt status.

One of the contractors, Southern California HMO, has applied for Federal qualification and was provisionally qualified by the State on 2/23/77. The final contractor, Contra Costa County, has applied for qualifcaiton, but currently has a special exemption from the qualification requirements from the Under Secretary based on its status as a demonstration site for the Prepaid Health Research, Evaluation and Demonstration Project (Grant Number 96-P-90299/9-02).

Two additional contractors are expected in early 1979: Kaiser Health Foundation - Northern California (a qualified HMO) and Group Health Services Plan (exempt due to its PHS grantee status). One of the State's current contracts, HANC, will not be renewed in 1979. The State has not renewed its contract with HMO Concepts, Inc. which terminated on January 31, 1979.

All of the contracts are risk based. The PHPs/HMOs are responsible for provision of all covered services to each enrollee, regardless of cost, in exchange for the monthly capitation payment. However, the risk is limited to a maximum of $10,000 per enrollee for each 12 month period commencing with the date specified in the contract. The contractors retain any savings that result from capitation monies not expended for services or administration. The contractors are also allowed to obtain reinsurance in the same amounts allowed in the Federal HMO regulations.

The HMO Amendments of 1976 require that risk based contractors have an enrolled population of not more than 50% Medicaid/Medicare beneficiaries. Qualified HMOs have until October 8, 1979 or three years from the initial date of their State contracts, whichever is later, to meet this requirement. Provisional HMOs must meet this same requirement. Organizations exempt from HMO qualification must submit applications to the Regional Medicaid Office for a waiver from the enrollment mix requirement.

Six of the State's 8 qualified HMO contractors already meet the enrollment mix requirement. These are:

1. CMGHP
2. FHP
3. FHS
4. HANC
5. Kaiser - South
6. Maxi-Care

A seventh contractor, NEVHC, also meets the membership mix. The two remaining qualified HMOs, SLACHP and Rockridge, must meet the mix by the October deadline or lose their Medi-Cal contracts. The State's one provisionally qualified HMO, Southern California HMO, also must meet the requirement by the October date. The two contractors that are exempt due to their PHS grantee status, Watts Health Foundation and Family Health Foundation of Alviso, must submit waiver applications to the Regional Medicaid Office. Contra Costa County is considered exempt due to its demonstration site status and also must apply to the Regional Office for a waiver.

All the HMOs provide the basic health services as described in P.L. 94-460. The excluded services from all the contracts are mainly related to long term institutionalization and are obtained by a PHP/HMO enrollee through State issuance of a regular Medi-Cal card and disenrollment of the individual. Kaiser is the only contractor not providing dental care; Kaiser enrollees receive a separate dental-only Medi-Cal card from the State.

The HEW Audit Agency did an audit of California's PHP program in 1977. The final report (ACN #80215-09)contains thirty-one recommendations for program improvement and one recommendation that California refund about $425,000 to HEW because the State had reimbursed fee for service providers for services provided to Medi-Cal recipients who were enrolled in PHPs. A major part of our PHP assessment was a determination of California's implementation of changes in its PHP program that were recommended by the HEWAA. All but nine of the 31 program recommendations have been satisfactorily addressed by the State. We will continue to work with the State to insure implementation of corrective actions that comply with the remaining recommendations.

Organization

The prepaid health program is administered by the Alternative Health Systems Division (AHSD) of the Department of Health Services. This Division has approximately 65 staff members and is divided into three branches--Prepaid Health Plan Branch, Quality Evaluation Branch (QEB) and Pilot Projects Branch (see attached chart). The PHP and Quality Evalutaion Branches are those most involved with the State's PHPs/HMOs. The Pilot Projects Branch's involvement directly with PHP/HMO is in the negotiation and development of new contracts. The Pilot Projects Branch has about 15 staff members who, in addition to their PHP contract development functions, are responsible for the monitoring of 2 large health insuring contracts. These are with the California Dental Services (CDS) and the Redwood Health Foundation (RHF). CDS is the fiscal intermediary for most Medi-Cal dental claims and has a risk capitation contract with the State. RHF is a regional fiscal intermediary that pays for services obtained by Medi-Cal eligibles within a 3 county area in Northern California. RHF also has a risk contract but is not a provider of services.

The PHP Branch has day to day contract management responsibility, complaint handling, and policy regulation development. The primary contacts with the PHPs/HMOs are through the contract manager staff. Each manager has certain contracts for which he/she is responsible. This responsbility encompasses audit follow-up (discussed below), technical assistance, site visits to assure contractor compliance, and involvement in public hearings related to the contractors. There are currently four such managers to handle the 13 contracts. There will shortly be 2-3 additional contracts. Although staff additions are anticipated for this activity, it appears that currently this function is understaffed.

The contract managers are rotated periodically in order to retain sufficient objectivity. This rotation can, however, contribute to gaps in sufficient monitoring of the contractors while the new manager is learning about the contractor's operation.

The QEB is responsible for the annual audits of the contractors and follow-up on the audit findings. There is currently a combined audit activity encompassing medical, financial and management aspects of the contractors. The AHSD is in the process of transferring the management audit functions from the PHP Branch to the QEB. However, it is expected that the management audit function and follow-up of findings will be the responsibility of the contract manager staff for about another 6 months until the QEB is staffed and trained to assume this responsibility.

The AHSD issues instructions and guidance to its contractors through sequentially numbered documents referred to as PHP Letters. There are currently 80 of these letters in circulation, some of which supersede others. The PHP Letters serve as elaboration of State regulation and clarification of policy.

Monitoring Systems

A. Overall

The AHSD has developed an extensive monitoring and control system for its contractors. The annual combined audits are the most important of these mechanisms and will be discussed in detail later. Most contracts follow standard language developed by this Division and approved by the Regional Office.

In December 1977, the State's prepaid health legislation was substantially amended. These amendments required revision of the standard contract language. This revision has been completed and was approved by the HEW Regional Office in December 1978. The contract renewals and new contracts in 1979 will follow the model language in the new standard contract.

The State requires quarterly reports on grievances, affirmative action, utilization of services and newborns from each plan except Kaiser. The contractors must submit all marketing materials to the State for prior approval and the contractors' enrollers are tested by AHSD.

Another State agency, the Department of Corporations(DoC), also has approval authority for the marketing materials and licenses the enrollers. DHS and DoC are not coordinating their review and approval of marketing materials nor requiring the same information in them. This dual approval requirement combined with different content requirement is causing some contractors to use marketing materials that are not fully in compliance with DHS requirements. This is a violation of their Title XIX contract.

B. Subcontract Approval

One provision of the PHP/HMO standard contract is that the contractor execute written subcontracts with all entities providing services related to the responsibilities under the Title XIX contract except:

1) seldom used or unusual services (as defined individually in dollar volume and number of referrals for each contractor)

2) emergency services out of service area

3) supplies/materials obtained through a vendor.

There has been confusion at DHS over the past year on exactly the number and type of the contractors' arrangements for delivery of services that need to be formalized in a subcontract. The estimate has varied from over 700 to about 150. The new standard contract, which incorporates the provisions of the 1977 State PHP amendments, has defined what services must be under a formal subcontract and will have a definite, contractor-specific definition of "seldom used or unusual serivces".

All subcontracts must be submitted to AHSD for prior approval. The PHP Branch staff responsible for this review and approval have specific checklists for identifying the required elements in the subcontracts; one checklist relates to medical services subcontracts and the other to administrative or marketing subcontracts.

The State Department of Corporations also must approve the subcontracts. DHS and DoC currently do not coordinate review and approval. This lack of coordination at the State level is cumbersome for the contractors who are trying to satisfy the two separate departments. Moreover, some of the contractors are prevented from fulfilling the provision of their Title XIX contract related to subcontract execution because DoC has required changes in subcontracts that DHS has approved. The contractors are trying to obtain the approval of both departments before they execute the subcontracts.

C. Complaint Processing

The State operates a toll free telephone line to receive complaints and provide information on Medi-Cal's PHPs/HMOs. Serious complaints on quality of medical care are referred to the medical professionals in the QEB for follow-up if the contract manager determines that this is necessary. Most phone calls relate to disenrollment requests rather than specific charges of a fraud and abuse nature. Currently State law requires that most disenrollment requests made after the 30 day grace period be processed through the contractor's formal grievance procedure. Consequently, most requests for disenrollment received by the State are referred back to the contractor to be processed through the grievance system with the intent that many disenrollments will be prevented by resolution of the enrollee's complaint and improvement of the contractor's operation.

D. Beneficiary Satisfaction Measurement

The AHSD is required by State law to do an annual beneficiary satisfaction survey for PHP/HMO enrollees. This process is done via a mail questionnaire. This mechanism is not considered an effective measure of enrollee satisfaction by AHSD staff because of the poor return of questionnaires and the difficulty in developing a meaningful questionnaire to distribute. The complaint handling process described above in combination with the quarterly grievance reports, testimony given at renewal hearings on contractors, and site visit interviews are considered much more reliable reflections of beneficiary satisfaction than the annual questionnaire. The DHS intends to recommend elimination of this annual survey requirement in legislation next year.

One aspect of the Prepaid Health Research Evaluation and Demonstration Project (PHRED) is a testing of various mechanisms to weigh the level of beneficiary satisfaction with the prepaid health plan enrollment. Any viable methods that result will be welcomed and adopted by AHSD.

E. Annual Combined Audits

AHSD conducts annual audits of each PHP/HMO. The audits include review of the management, medical, and financial aspects of the contractor. Specific guides are in use for this process. The medical audit team is headquartered in Los Angeles and consists of physicians, nurses, dentists, pharmacists and health facility specialists. California's medical audit manual has been reviewed by the Region IX Health Standards and Quality Bureau and found to be comprehensive. The State's process for deciding whether the PHPs/HMOs are delivering quality care appears adequate. (There are no definitive HEW standards in this area, so little can be done at this time by the Regional Office to specifically monitor quality of care.) The medical audit team is responsible for following medical findings through to resolution. Such follow-ups are occurring and for the most part include site visits.

Auditors conduct the financial portions of the annual reviews. The DHS measures the contractor against five financial viability factors:

1) Tangible Net Equity
2) Level of General and Administrative Expenses
3) Profit and Loss Statement
4) Trend Information
5) Working Capital Ratio

DHS is attempting to coordinate its audit efforts with those of the State DoC or at least to share information to avoid duplication where possible. There is also a desire to standardize certain financial requirements of the two departments in order to make overall compliance with State regulations easier for the contractors. As part of this attempt at coordination, DHS relies on the DoC regulatory limits on levels or general and administrative costs. However, the DoC regulations are not definite on the levels allowable, but leave much discretion to the Commissioner of DoC. This to some extent leaves DHS in the position of relying on a financial viability measurement of DoC and upon DoC's enforcement of it.

The management audit is concerned with verifying the contractor's administration, subcontract status, grievance system, marketing operation, utilization data collection system, facility conditions and enrollemnt verification process. It is the responsibility of the contract manager to track and ensure the resolution of any negative findings in these areas. Most audit findings are being tracked by the managers and any problems resolved.

Rate Setting

A major portion of the Prepaid Health, Research and Demonstration Project (an HEW Section 222 grant to California) has been the development of an actuarial rate setting methodology for Title XIX contracts with PHPs/HMOs. This component of PHRED is complete and the 1978-79 rates for California's PHPs/HMOs are based on the PHRED methodology.

California's fiscal year starts July 1 and its annual Medi-Cal rate revisions are effective then. The PHP/HMO contract effective dates are all different from July 1 so the State changes the capitation rates for its contractors by amendment annually to coincide with the State's budget cycle.

The rate development process for FY 78/79 was a combined effort of the PHRED project and the AHSD, and involved the following stages:

1. Development of utilization and cost assumptions based on data reported by the PHPs/HMOs and derivation of standard rates from these assumptions.
2. Application of adjustments (in the areas listed below) to the standard rates in order to arrive at rates for each PHP:
    a) Age/sex mix
    b) Medicare coverage
    c) Expanded mental health coverage, third party liability and EPSDT screening.
3. Application of risk sharing formula to allow for predictive uncertainity related to (a) utilization assumption for three adult aid categories and (b) impact of reduced abortion coverage on the AFDC delivery rate.
4. Substantiation that the proposed rates will be less than fee for service per capita costs.
5. Observation of contrast between Medi-Cal capitation rates and PHP commercial rates, although without the detailed adjustments needed to make a formal comparison.

A detailed explanation of the rate setting process is included in the new standard contract. The methodology was reviewed and approved by the Regional Office.

PHRED

The Prepaid Health Research, Evaluation and Demonstration (PHRED) Project is a multi-year grant project to California from HEW under section 222 (a) of P.L. 92-603. The initial component of the project, development of a rate setting methodology, is complete and has been discussed above. The remaining components, quality assurance and membership studies (marketing, grievance and beneficiary satisfaction), have been funded and are in progress. The AHSD is kept informed of PHRED's activities and contributes comments and suggestions on various aspects of the project.

AHSD anticipates incorporating the products of PHRED, as it has the rate methodology, and has a good working relationship with the project managers.

Findings and Recommendations

The AHSD has made extensive improvements in its administration of the Medi-Cal PHP/HMO program since the period covered by the most recent HEW audit of the program. For the most part the monitoring and control functions are working well. There are needed improvements in the State's operation and these are discussed below.

The problem areas discussed below are in order of their importance with the most serious first.

I. DHS/DoC Coordination

As discussed in several areas of this report certain activities of the DoC are impacting on the ability of some of the PHPs/HMOs to comply with provisions of their contracts with DHS. Specifically, these areas are:

a) execution of subcontracts
b) use of appropriate marketing materials
c) compliance with required general and administrative expense limits.

These 3 areas appear to be within the two State agencies' power to resolve.

Recommendations:

1. DHS develop uniform subcontract requirements with DoC and a concurrent subcontract review to eliminate the duplicate requirements on the contractors and reduce the processing time in order for the contractors to comply with the execution time requirements in their Medi-Cal contracts.

2. DHS convene a working group comprised of DHS, DoC and representatives from the PHPs/HMOs and develop uniform marketing brochure language that will meet the requirements of both Departments.

3. DHS obtain from DoC its position on the reasonable general and administrative expense levels for each Medi-Cal contractor; or DHS revise its regulatory reliance on DoC's determination and enforcement of appropriate G&A expense levels.

4. Coordination to the maximum extent possible of the on-site audits by DHS and DoC in order to reduce the time required of the contractor to meet with auditors and provide documentation.

II. Subcontract Review and Approval

As of November 14, 1978, Kaiser was the only PHP/HMO Medi-Cal contractor that was in compliance with its contract in the area of execution of State approved subcontracts. There were a total of 115 subcontracts approved by the State of an approximate 177 required; 43 had not been received from the contractors.

Recommendations:

1. DHS should clarify for each contractor the specific subcontracts required and establish dates for execution of these subcontracts.

2. DHS should insure expedient processing of subcontracts with AHSD by better coordination activities of the subcontract reviewer and contract managers.

3. DHS should require as a condition of contract continuation existence of the required subcontracts by a specified date.

III. Control Over Duplicate Payments

Based on documentation provided during the assessment it appears that the State is just initiating some of the controls it has proposed to prevent fee for service payments being made for PHP enrollees. The first findings of a Medi-Cal Quality Control review of this issue was to be available in January 1979. What will be done with findings of payments made on improper issuance of temporary Medi-Cal cards has not been decided as yet. The State has developed various proposals to modify the PHP eligibility control system to insure that the PHPs are properly capitated for enrollees. However, this process is at the stage of staff recommendations. The staff's primary recommendations, if accepted, cannot be operational for about 4 months from the decision date.

Recommendations:

1. DHS should determine how it will reimburse HEW for any amounts resulting from improper fee-for-service payments made for PHP enrollees.

2. A decision should be made by DHS management on which resolution to the eligibility determination problem proposed by its staff will be adopted so that they can proceed as soon as possible with implementation.

IV. Use of Sanction Authority

The December 1977 amendments to the Waxman-Duffy Act strengthened the administrative and financial sanctions available to DHS for use when a PHP/HMO violates its Medi-Cal contract. Regulations issued by the State effective August 5, 1978, elaborate upon the types and, in the case of monetary penalties, the amounts related to various violations. However, the specific steps to document and impose such penalties are not yet defined by the State. The sanction authority has not yet been applied.

Recommendation:

DHS should define the necessary documentation and related time frames required in order to apply the sanctions allowed for in Section 53350, Title 22.

V. Combined Audits

Through our on-site observation of one management and financial review and comparison of the activities at this audit with the State's review guides, we feel that this function could be improved through adoption of the following recommendations.

Recommendations:

1. DHS should improve management audit staff preparation by specifying how each component of the audit will be accomplished and what documentation is required. This is especially needed in the areas of subcontract documentation, utilization data and determination of administrative influence over medical decisions.

2. New staff should not be left on their own to conduct portions of the audit unless they have received specific instruction on how to proceed.

3. Participation of the contract manager in the audit should be avoided in order to assure objectivity.

4. Interaction between the management and medical audit staff should be increased to strengthen the findings in several areas, particularly the determination of administrative influence on medical decisions and the handling of quality of care grievances.

5. The current management audit guide steps for verification of utilization data should be revised because they cannot be followed. This is due to the incompatibility of the utilization categories listed in the guide with those for which the PHPs/HMOs collect utilization data for their quarterly reports to the State.

6. Management audit staff should have a thorough understanding of the allowable legal and financial relationships between the contractor and other entities in order to make a determination on the propriety of the subcontractual arrangements and the status of the contractor's compliance with the prohibition against self dealing.

7. The following steps of the management audit guide were not done during the audit observed. These steps should either be done uniformly at all audits, eliminated from the guide, or revised to reflect actual process:

    a) Observation of enrollers in field.
    b) Determination that "meaningful" attempts are being made to enroll people in all aid categories.
    c) Determination that staffing composition of the plan reflects affirmative action principles.
    d) Interview with nursing supervisor.
    e) Observation of grievance staff for several hours over several days (observation was minimal on one day).
    f) Review of backup material for sample grievances.
    g) Determination that quality of care grievances are being appropriately identified and referred to medical director.

h) Most of the steps under the subcontract section of management audit guide.

i) Determination that all management services are provided by plan employees (definition of "management services" was unclear).

VI. Resolution of State Audit Findings

Although the AHSD is making a good effort to ensure that all its negative audit findings are resolved, in many cases the same findings are recurring at the same contractors in subsequent audits. This was the case in 4 of the 5 PHPs/HMOs reviewed during the assessment.

Recommendations:

1. DHS should use recurrence of negative findings as basis for application of sanctions provided for in new State regulations.

2. DHS should improve the transition of the monitoring of PHPs/HMOs from one contract manager to another to ensure that all audit findings are understood and accounted for.

VII. Staffing

There are currently four contract managers and four financial and management audit staff members. One contract manager is responsible for four contractors and the other three managers have three plans each. Adequate monitoring of the contractors does not appear possible with this number of staff. The contract managers have recently been given the additional responsibilities of approving marketing materials and certification of enrollers. Moreover, three additional contractors are expected in early 1979.

Relative to the number of QEB audit staff, the November 1978 combined audit to HMOC did not include a financial review because of lack of staff.

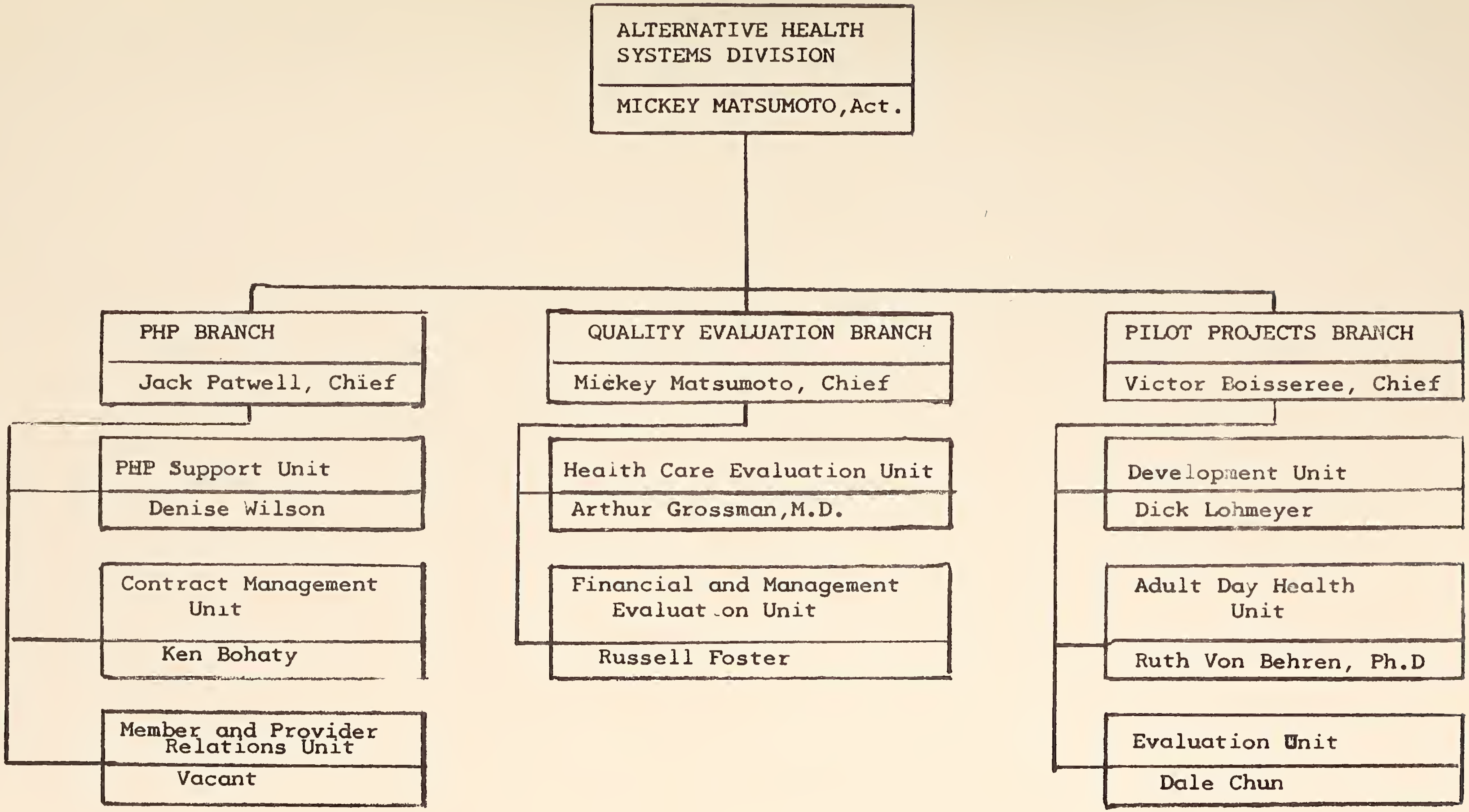
Recommendation:

AHSD should increase its staff levels in the contract manager and audit areas to ensure adequate monitoring of the assistance to the PHPs/HMOs.

APPENDIX

This review included interviews with staff and review of files in Sacramento and observation of the management audit at HMOC (11/6-10, 1978) and of the financial review of the Family Health Foundation of Alviso (12/4-8). Analysis of documents at HEW Regional Office was also involved.

DIVISION ORGANIZATION CHART


ALTERNATIVE HEALTH SYSTEMS DIVISION
MICKEY MATSUMOTO, Act.
PHP BRANCH
Jack Patwell, Chief
PHP Support Unit
Denise Wilson
Contract Management Unit
Ken Bohaty
Member and Provider Relations Unit
Vacant
QUALITY EVALUATION BRANCH
Mickey Matsumoto, Chief
Health Care Evaluation Unit
Arthur Grossman, M.D.
Financial and Management Evaluation Unit
Russell Foster
PILOT PROJECTS BRANCH
Victor Boisseree, Chief
Development Unit
Dick Lohmeyer
Adult Day Health Unit
Ruth Von Behren, Ph.D
Evaluation Unit
Dale Chun

EDITORIAL NOTE

THE REMAINING PORTION OF THIS DOCUMENT CONSISTS OF MATERIAL SUBMITTED BY THE STATE OF CALIFORNIA"S DEPARTMENT OF HEALTH SERVICES, IN RESPONSE TO THE MEDICAID BUREAU'S FINAL DRAFT OF THE ASSESSMENT REPORT. AS HAD BEEN PREVIOUSLY AGREED, CERTAIN FACTUAL ERRORS NOTED BY THE STATE HAVE BEEN CORRECTED IN THE ORIGINAL TEXT. HOWEVER, ALL COMMENTS SUBMITTED BY DHS ARE INCLUDED, WITH ANY ITEM WHICH HAS LED TO A CHANGE IN THE ASSESSMENT REPORT ITSELF NOW MARKED IN THE RIGHT-HAND MARGIN BY THREE VERTICAL ASTERISKS. SUCH ITEMS CAN BE FOUND IN FOUR SECTIONS:

B - ADMINISTRATION & MANAGEMENT - PAGES 2 and 8

E - REIMBURSEMENT - PAGE 21

F - EPSDT - PAGES 24-26, 29 and 30

K - LONG-TERM CARE - PAGE 61

IN ADDITION, IN AN EFFORT TO MINIMIZE THE BULK OF THIS ENTIRE DOCUMENT, THE 30 PAGES OF ATTACHMENT III OF THE EPSDT SECTION, BEGINNING ON PAGE 31, HAVE BEEN REMOVED BUT ARE AVAILABLE FROM THE CHDP BRANCH, DHS.

STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY
EDMUND G. BROWN JR., Governor

DEPARTMENT OF HEALTH SERVICES
714/744 P STREET
SACRAMENTO, CA 95814
(916) 322-7202

HCFA/IX
MEDICAID BUREAU
JUN 15 11 08 AM '79

June 15, 1979

Mr. Lawrence L. McDonough
Regional Medicaid Director
Department of Health, Education and Welfare
Health Care Financing Administration
100 Van Ness Avenue
San Francisco, CA 94102

Dear Larry:

Attached is the response of the Department of Health Services California Medicaid Management Assessment. I apologize for the delay in responding.

I do appreciate your willingness to include the comments of our staff in the appendix of the final report so that in areas where the DHEW and DHS positions differ, our opinions will receive an equal airing.

Should you need clarification on any of the information contained in the report, please contact Margaret De Bow at (916) 322-7202.

We will look forward to receiving the final report.

Sincerely,

Beverlee A. Myers
Director

Attachment

Department of Health Services

Response to

Medicaid State Management Report
California Title XIX Program
August-December 1978

Beverlee A. Myers
Director
Department of Health Services
State of California

Section B
Administration and Management

General Comments

II. Organization

B. Structure and Interrelationships

(1) Department of Health Services (DHS)

We would like to update Section ~~13~~ B on Page 2 to reflect the April 1, 1979 reorganization. Under the Chief Deputy Director for Medical Care Services, there are two divisions and two sections. The divisions are:

(a) The Medi-Cal Division which encompasses the Operations Branch, Prepaid Health Plans Branch, and Procurement Project Branch.

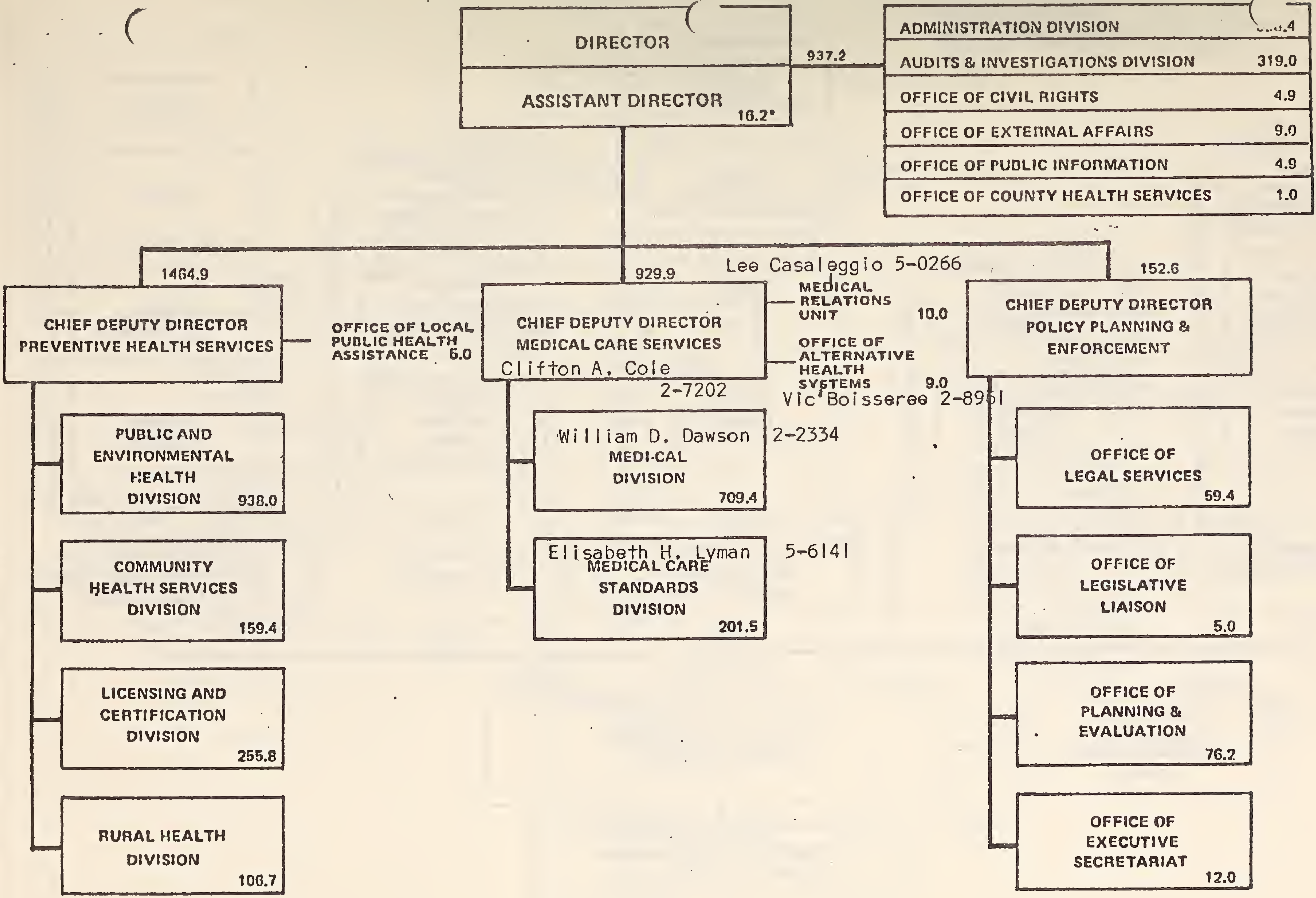
(b) The Medical Care Standards Division which includes Prepaid Health Research, Evaluation and Demonstration Project (PHRED), the Benefits Branch, the Child Health and Disability Prevention Branch (CHDP), the Eligibility Branch, and the Rate Development Branch.

The two sections of the two offices that report directly to the Chief Deputy Director for Medical Care Services are:

(a) Medical Care Relations Unit.

(b) The Office of Alternative Health Systems which is a modification of the previous Alternative Health Division which contained prepaid health plans, health maintenance organization contracts, and pilot projects. Prepaid plans and health maintenance organization contracts have now been placed in ongoing operations in the Medi-Cal Division, and pilot projects and the Medi-Cal health initiatives development have been placed in the Office of Alternative Health Systems.

Effective May 1, 1979, Mr. Clifton A. Cole is the Chief Deputy Director for Medical Care Services and a more distinct division of workload with separate division directors and branch chiefs has been established and delineated. Duties previously assigned to other persons have now been returned to the Chief Deputy Director's Office and a clear line of authority has been established. (See attached organization chart.)


DIRECTOR
ASSISTANT DIRECTOR 16.2*
937.2
ADMINISTRATION DIVISION [illegible].4
AUDITS & INVESTIGATIONS DIVISION 319.0
OFFICE OF CIVIL RIGHTS 4.9
OFFICE OF EXTERNAL AFFAIRS 9.0
OFFICE OF PUBLIC INFORMATION 4.9
OFFICE OF COUNTY HEALTH SERVICES 1.0
1464.9
CHIEF DEPUTY DIRECTOR PREVENTIVE HEALTH SERVICES
OFFICE OF LOCAL PUBLIC HEALTH ASSISTANCE 5.0
PUBLIC AND ENVIRONMENTAL HEALTH DIVISION 938.0
COMMUNITY HEALTH SERVICES DIVISION 159.4
LICENSING AND CERTIFICATION DIVISION 255.8
RURAL HEALTH DIVISION 106.7
929.9
CHIEF DEPUTY DIRECTOR MEDICAL CARE SERVICES
Clifton A. Cole 2-7202
Lee Casaleggio 5-0266
MEDICAL RELATIONS UNIT 10.0
OFFICE OF ALTERNATIVE HEALTH SYSTEMS 9.0
Vic Boisseree 2-8961
William D. Dawson 2-2334
MEDI-CAL DIVISION 709.4
Elisabeth H. Lyman 5-6141
MEDICAL CARE STANDARDS DIVISION 201.5
152.6
CHIEF DEPUTY DIRECTOR POLICY PLANNING & ENFORCEMENT
OFFICE OF LEGAL SERVICES 59.4
OFFICE OF LEGISLATIVE LIAISON 5.0
OFFICE OF PLANNING & EVALUATION 76.2
OFFICE OF EXECUTIVE SECRETARIAT 12.0

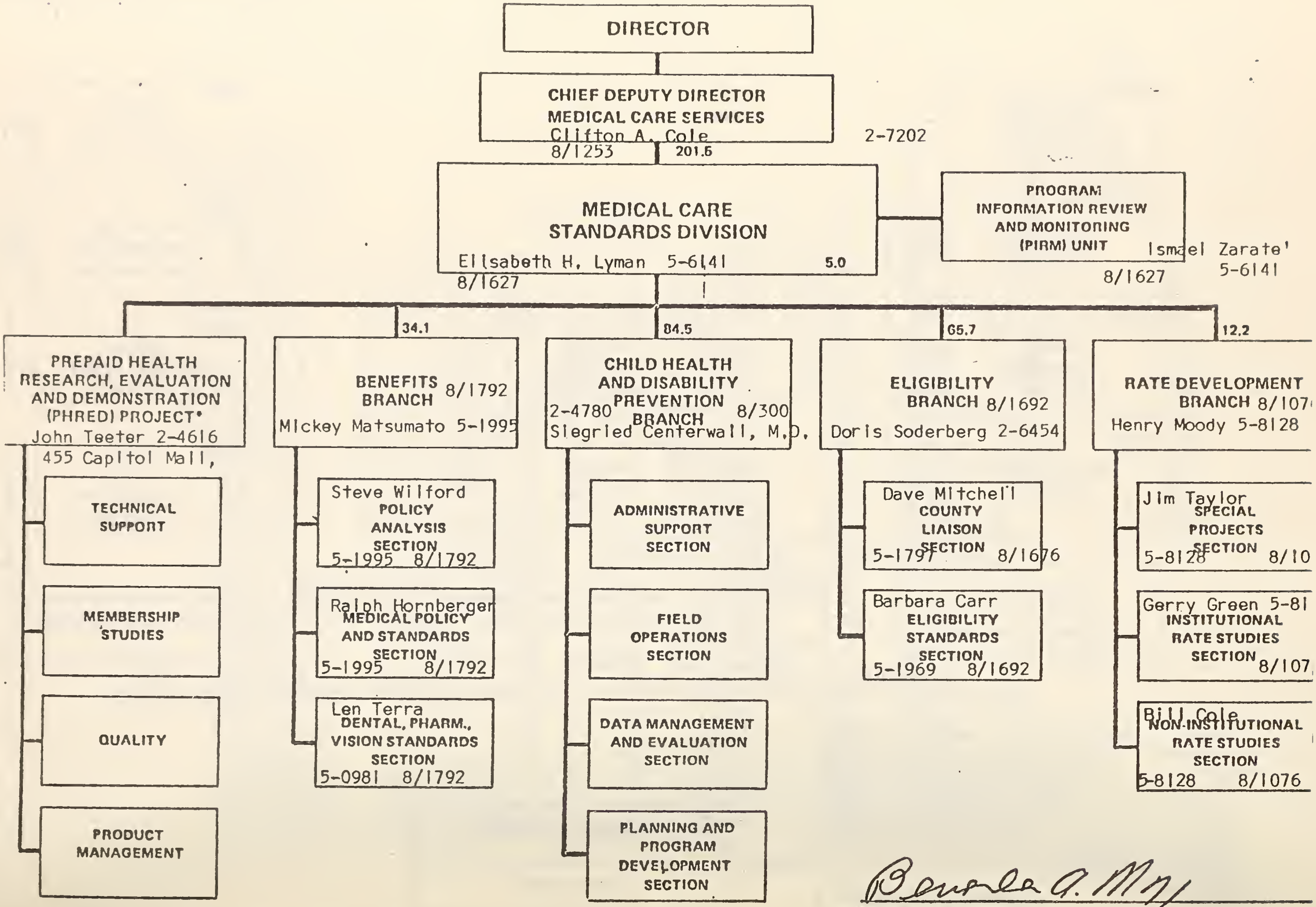
* Includes Chief Deputy Directors and their staffs.

Beverlee A. My

BEVERLEE A. MYERS

4/1/79

CALIFORNIA DEPARTMENT OF HEALTH SERVICES


DIRECTOR
CHIEF DEPUTY DIRECTOR
MEDICAL CARE SERVICES
Clifton A. Cole
8/1253
201.6
2-7202
MEDICAL CARE STANDARDS DIVISION
Elisabeth H. Lyman 5-6141
8/1627
5.0
PROGRAM INFORMATION REVIEW AND MONITORING (PIRM) UNIT
Ismael Zarate'
5-6141
8/1627
34.1
84.5
65.7
12.2
PREPAID HEALTH RESEARCH, EVALUATION AND DEMONSTRATION (PHRED) PROJECT*
John Teeter 2-4616
455 Capitol Mall,
TECHNICAL SUPPORT
MEMBERSHIP STUDIES
QUALITY
PRODUCT MANAGEMENT
BENEFITS BRANCH 8/1792
Mickey Matsumato 5-1995
Steve Wilford
POLICY ANALYSIS SECTION
5-1995 8/1792
Ralph Hornberger
MEDICAL POLICY AND STANDARDS SECTION
5-1995 8/1792
Len Terra
DENTAL, PHARM., VISION STANDARDS SECTION
5-0981 8/1792
CHILD HEALTH AND DISABILITY PREVENTION BRANCH
2-4780 8/300
Siegried Centerwall, M.D.
ADMINISTRATIVE SUPPORT SECTION
FIELD OPERATIONS SECTION
DATA MANAGEMENT AND EVALUATION SECTION
PLANNING AND PROGRAM DEVELOPMENT SECTION
ELIGIBILITY BRANCH 8/1692
Doris Soderberg 2-6454
Dave Mitchell
COUNTY LIAISON SECTION
5-1797 8/1676
Barbara Carr
ELIGIBILITY STANDARDS SECTION
5-1969 8/1692
RATE DEVELOPMENT BRANCH 8/107
Henry Moody 5-8128
Jim Taylor
SPECIAL PROJECTS SECTION
5-8128 8/10
Gerry Green 5-81
INSTITUTIONAL RATE STUDIES SECTION
8/107
Bill Cole
NON-INSTITUTIONAL RATE STUDIES SECTION
5-8128 8/1076

Beverlee A. Myers

BEVERLEE A. MYERS

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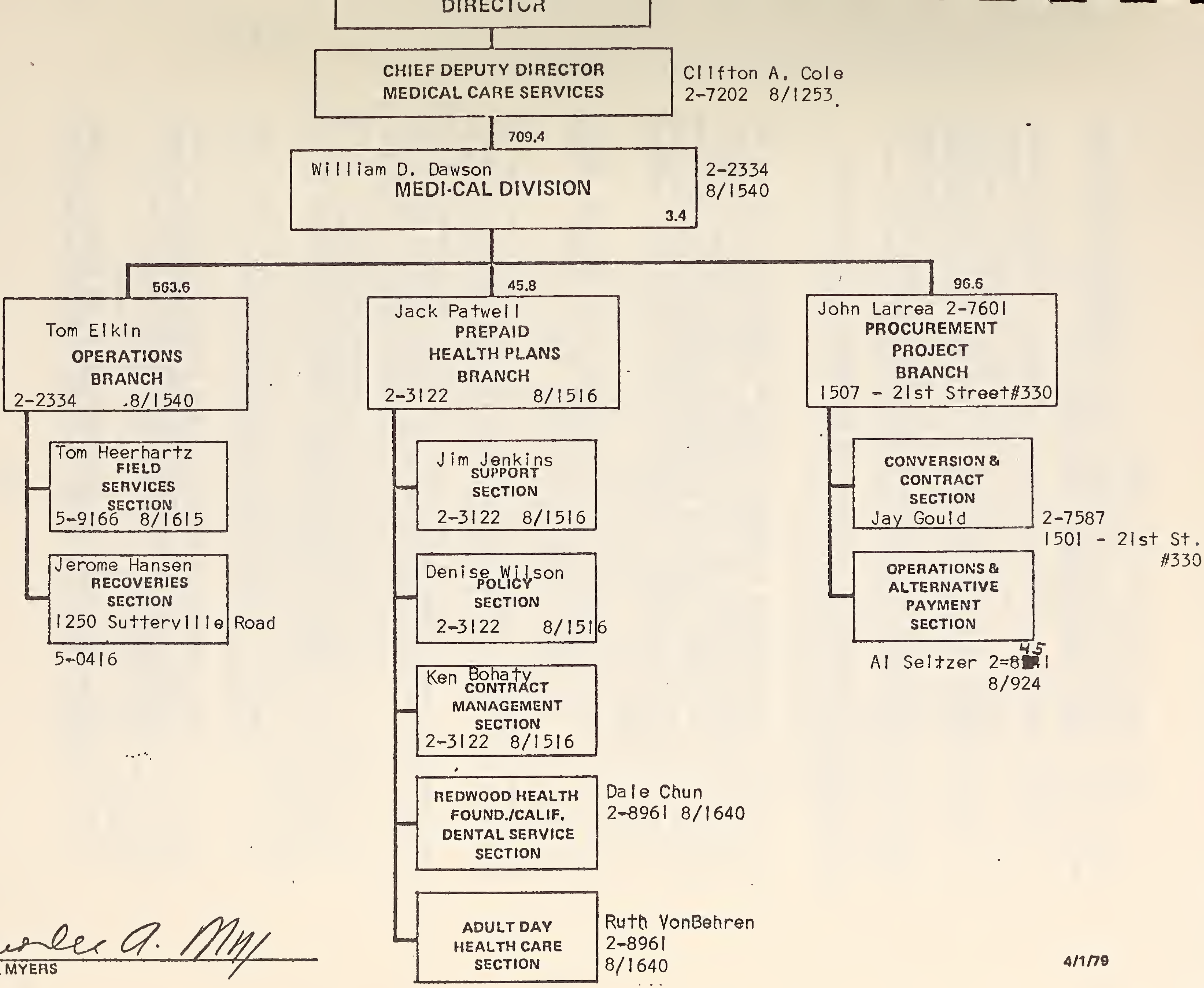
* Not in Governor's budget — 100 percent federally funded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4/1/79

(6) County Welfare Offices (CWOs)

Correction should be made to the paragraph which describes direct liaison between CWOs and DHS.

The County Liaison Section of the Medi-Cal Eligibility Branch consists of seven field representatives who have ongoing contact with county welfare departments' Medi-Cal staff, two supervisors (one supervisor is also the field representative for Los Angeles County), and one manager. Field representatives visit each county once per quarter to review policies and procedures, discuss eligibility problems, assist with training, discuss new and proposed regulation changes, etc.

C. Problems and Conflicts Between DHS Headquarters and the Field

(2) County Welfare Offices

Clarification is needed. Program eligibility staff of DHS and Department of Social Services (DSS) are in constant communication regarding ongoing policy and impending changes. The reason that there are differing eligibility regulations for Aid to Families with Dependent Children (AFDC) and medically needy (MN) recipients is due to the federal Medicaid regulations which require:

(a) For income, that MN recipients be allowed the income exemptions and disregards of the cash program to which they are categorically linked, and

(b) For resources, that resources be treated the same for all MN recipients, using the more liberal cash grant program's treatment for each resource item. Since the Supplemental Security Income/State Supplementary Payment (SSI/SSP) program is more liberal than the AFDC program in its treatment of the various resource items, MN recipients resource requirements generally coincide with the SSI/SSP program's eligibility requirements. Consequently, federal Medicaid regulations require that MN recipients have different eligibility requirements than AFDC recipients.

Further, federal Medicaid regulation prohibit prior month budgeting (42 CFR 435.831 (a)). * * *

The assessment reports that CWOs complained about DHS headquarters requesting information and reports which were previously supplied to the Department rather than relying upon its own records.

We maintain that increased coordination of effort and communication between units within DHS is preventing duplication of requests for information. Wherever possible Medi-Cal Eligibility staff relies upon data available within the Department rather than requesting additional reports from CWOs. Additional data is requested from the counties in order to update and expand information previously supplied.

Counties also complain that they have neither time nor staff to follow up on beneficiary requests for additional proof of eligibility (POE) labels and replacement Medi-Cal cards.

Authorization for counties to issue Medi-Cal cards was granted to afford beneficiaries immediate access to Medi-Cal cards when faced with urgent medical needs. Counties have the choice of issuing the card or of requesting the Department to issue the card based on the beneficiary's need. Approximately 200,000 cards are issued by the counties each month.

Recognizing the workload burden placed on the counties, the cost involved, and the potential for error in county produced cards, one feature of the new Medi-Cal Eligibility Data System (MEDS) now under development will be on-line computer print terminals located in county offices. These terminals will be linked directly to a Department operated master eligibility file. Upon minimal on-line data input from the county, the system will accept a card issuance request, verify the beneficiary's current eligibility, and produce a card for the worker to hand to the beneficiary. It is anticipated that the entire transaction will take less than two minutes to complete and will significantly reduce county workload in this area. Present plans call for implementation of this system to begin in November 1979 and to be installed in all counties by March 1981.

Counties noted it takes a significant amount of time after eligibility certification for a share-of-cost (SOC) beneficiary to receive a Medi-Cal card.

Under the SOC procedures, counties may issue immediate need Medi-Cal cards to SOC beneficiaries upon receipt of documentation that the beneficiary has met the SOC. However, in most instances, the SOC documentation is sent to the Department for eligibility certification and card issuance. This may take up to three weeks.

We anticipate the new eligibility system described above will enhance the SOC process in two ways. First, it will reduce the county workload involved with immediate need card issuance. Thus, county staff can be more responsive to the needs of SOC clients with respect to issuing Medi-Cal cards. Secondly, the new system will significantly reduce the Department's workload involved in issuing SOC cards. Currently, all of the data necessary to produce the SOC card must be key entered to the card issuance system each time an SOC card is requested. Under the new system, only minimal data input will be required to generate an SOC identification card.

X. Consumers

The assessment team noted there were inadequate contacts with consumer groups. The implication that there is a lack of input from consumer groups on the Medi-Cal program or policies is incorrect. While the input is, or may be, on an ad hoc basis, it is continuing, even though centered around specific issues.

As a case in point, the significant changes in July 1976 (Medi-Cal Simplification) which substantially liberalized the California Medicaid program and eased the burden on consumers in regard to Medi-Cal eligibility were initiated by an advisory group which contained substantial consumer representation. These representatives fully supported the results of the committee deliberations.

Several sources serve as input pipelines to the Department. These are:

1. Public hearing process on regulation changes -- Welfare rights and legal aids organizations are well represented on the list of groups who get proposed regulations (or regulation changes when filed on an emergency basis) sent to them. These organizations regularly testify at the hearings.

2. Fair hearings -- Fair hearings provide direct input from dissatisfied Medi-Cal applicants/recipients to the Department. Department staff review for correctness and for possible program improvements on behalf of the beneficiaries.

3. Regulation petition process -- California state law, like federal law, requires that petitions for program changes requiring regulation changes to implement be evaluated and responded to within a specified time period.

4. County welfare department representatives -- The county welfare directors (CWDs) meet monthly in committee with DHS staff. There is also continual contact between this group and state eligibility staff. The CWD is probably the most effective consumer advocate group on an ongoing basis and is as concerned for the welfare of the consumer as any consumer representative. (Those who doubt this statement should plan to attend one of the monthly meetings!)

The consumer groups expressed the following major concerns which we would like to respond to:

1. Eligibility workers are usually young, with only a high school education, receive little training, are poorly paid, have heavy workloads, and caseload assignments change frequently.

The eligibility worker classification is generally an entry level series; consequently, many eligibility workers are young. The turnover rate is relatively high statewide, since many workers are promoted into the eligibility supervisor series or move on to other classifications. Because the turnover rate among eligibility workers is high, caseload assignments may change frequently.

Response

Most welfare departments require eligibility worker applicants to have only a high school education; however, many are college graduates, particularly in urban areas. Training varies from county to county; however, all counties train new eligibility workers -- either on the job or in formal training sessions -- and provide ongoing training for all eligibility workers. DHS County Liaison staff work with counties to develop and coordinate Medi-Cal training as needed.

Salary levels vary considerably from county to county, with urban counties paying significantly higher salaries than more rural counties. Salary levels for eligibility workers, as for all other county employees, are determined by the local board of supervisors and are not subject to state control.

2. Adequate information regarding Medi-Cal covered benefits, program regulations, etc., is not available to Medi-Cal recipients and other welfare groups.

Response

Informational brochures describing the Medi-Cal program, services available, etc., are available in all CWOs; such information may also be obtained by telephone in all counties. During the application process applicants are informed of services available, their rights and responsibilities as Medi-Cal beneficiaries, etc. Applicants are also told that copies of Medi-Cal and DSS regulations are availale for use in the welfare department. Eligibility and services workers assist beneficiaries in obtaining medical care and refer beneficiaries to county clinics, county/contract or Hill-Burton facilities in the area, all of which provide free or low-cost health care. Most county welfare departments do not refer beneficiaries directly to private providers, but will either inform beneficiaries which providers in the area treat Medi-Cal patients or will refer the beneficiary to the county medical society for further referral to an individual provider.

3. Many medical providers are reluctant to treat Medi-Cal clients without receiving a Medi-Cal card at the time of service. Since there is a 45-day processing time for new applications, many applicants are unable to obtain necessary medical care for a considerable period of time.

Response

Medi-Cal regulations allow 45 days from the date of application for processing applications; most counties currently process routine applications within 15-20 days, however. In immediate need situations, counties can determine eligibility and issue a Medi-Cal card within 24 hours.

El Dorado County, which was specifically mentioned in the federal review report, was seriously understaffed at the time of the review. That situation has been resolved, however, and the county is currently processing most Medi-Cal applications within 30 days or less.

Provider access is a problem statewide, particularly in rural areas. Some providers prefer not to treat Medi-Cal patients, while others prefer to receive a Medi-Cal POE label at the time of service in order to facilitate billing. Routine medical care is usually available through county medical clinics, however, and emergency medical care can be obtained without presenting a Medi-Cal card at the time of service. Current Medi-Cal regulations allow retroactive eligibility for three months prior to the date of application, so that a provider will be paid for services rendered, so long as the patient applies and is determined eligible within three months of the date of service, and the patient then gives the provider a label.

XI. Recommendations

1. Single State Agency Requirement

The State should take whatever steps are necessary to place day-to-day control of the Medi-Cal program solely in the hands of DHS, as required under 45 CFR 205.100. In addition, however, because of Department of Finance's (DOF's) mandated involvement in the Medi-Cal budget, it is recommended that DOF staff become more knowledgeable about and involved in the program through inclusion in DHS staff discussions.

Response

We assume that when the Department of Health, Education, and Welfare (HEW) developed this recommendation it was intended to be included for the record only since California's governmental structure and the strong control role of DOF are already well-established. We also believe that the degree of exposure to and contact with DOF by DHS staff is greatly underestimated by HEW. We are in constant communications with Finance on even the most minor program changes, frequently during the embryonic stage of these changes. DOF staff also recently received training in Medi-Cal eligibility. We will, however, convey HEW's concerns over the potential violation of the single state agency requirements to the appropriate management level for action.

2. Fragmentation of Authority and Control

Recommendation

It is recommended that the State review the overall organization and administrative authority of those administering the Medi-Cal program, with consideration toward realigning functions to provide better coordination for field offices and CWO staff. The consolidation of authority for all eligibility determinations within DSS should be explored. The exclusive adoption of either prior month or current month budgeting for both DSS and DHS is also recommended. Finally, a formal, effective system of coordination and exchange of information is needed between DHS and DSS; between DHS headquarters and the field; and among the Medi-Cal field offices, the CWOs, and the Social Security Administration district offices (SSA DOs).

Response

This issue has been reviewed and discussed at length in the past. It is this Department's position that total responsibility for the Medicaid program, including eligibility determinations, should remain with DHS. This position is based upon the following:

1. Federal Medicaid "single state agency" requirements prohibiting such fragmentation of program responsibility.

2. Prudent program management principles of placing responsibility and accountability with one administrative organization.

3. Differing eligibility requirements (due to federal Medicaid regulations) between the AFDC cash program and the Medicaid program.

4. County Welfare Directors Association support of the continued organizational placement of the eligibility function within DHS.

   Prior month budgeting is prohibited by Medicaid regulations (42 CFR 435.831 (a)). Note: HEW staff have recently visited California to study the practice of using prior month budgeting within the Title IVA program. It is our understanding that changes may be made in the Title IVA regulations to permit prior month budgeting within AFDC programs. (However, a recent California Supreme Court decision, Garcia vs. Swoap, invalidated DSS regulations providing for prior month budgeting and remanded the case to the trial court for further proceedings. Final outcome of this decision has not yet been resolved by the trial court.)

The Medi-Cal Division is currently studying its Field Services Operation with a view toward a possible reorganization which would improve coordination between headquarters and the field.

3. Staffing

Recommendation

It is recommended that the State review its current allocation of resources and work toward increasing the number of physicians on DHS headquarters staff, with consideration given to more competitive salaries and stronger recruitment efforts; that a full-time Regulations and Compliance Coordinator be appointed, to report directly to the Chief Deputy Director for Medical Care Services; and that the major vacancies for clerical staff and social workers in Medi-Cal field offices be filled immediately. It is further recommended that procedures within the State Personnel Board be reviewed toward decreasing the usual time required to establish a list of eligibles for vacant positions. With respect to county staffing problems, it is recommended that the current cost allocation plan for counties be reviewed, with consideration given to increased staffing needs in CWOs based on factors in addition to actual caseload increases.

Response

DHS would also like to increase its staff in the areas mentioned. However, as HEW is well aware, we are in a staff reduction era as opposed to expansion. We have no indications that this situation will change in the immediate future. Regarding field office vacancies, filling of these positions has been authorized and considerable progress made since this report was prepared. It should also be noted that the physician shortage will be somewhat relieved with the expected hiring of these additional physicians between July 1 and September 1979. The Department has previously brought to the attention of the State Personnel Board its concerns over the length of time required to obtain hiring lists and will communicate HEW's recommendation to departmental Personnel staff for transmittal to the Personnel Board.

The assessment finding was that "Each county's allocation is *
reviewed annually, but can be increased only with an increase in *
overall caseload, and not with consideration of actual workload *
which may be influenced by other factors such as increased requirements, reports, etc."

This is an erroneous statement.

The current cost allocation plan provides for increasing a county's allocation for factors other than increased caseload. For example, the new regulations requiring quarterly status reports and an annual face-to-face redetermination required additional workload on the part of the county eligibility workers. The additional cost of implementing these regulations was added to the individual county allocations.

In addition, county allocations are reviewed throughout the year and adjusted to reflect changes in caseload and expenditure levels. Special adjustments to county allocations are also available, with adequate justification, for those counties who have unique circumstances which impact their workload and/or administrative costs.

4. Written Communications

Recommendations

Care should be taken to assure that there is appropriate coordination with all program areas, including AFDC, prior to issuance of any regulations or instructions, including any necessary legal interpretation. All DHS required forms and the instructions for completing such should be provided to field offices and CWOs in sufficient time and quantity for proper completion, and all issuances to field offices and CWOs should be numbered to assure receipt of all appropriate material. There should be some assurance that Medi-Cal bulletins are received in field offices and CWOs no later than they are received by the providers, and it is recommended that, as DHS takes over the provider relations function with the change in fiscal intermediaries, a Provider Relations Manual be established.

It is further recommended that training materials for CWO staff, and SSA DOs, be reviewed to assure that they are specific enough and available in sufficient quantities to meet their needs, and that handouts and brochures in sufficient quantity and specificity be made available to recipients through all CWOs and SSA DOs. Finally, Medi-Cal recipients should be informed that manuals and regulations are available for their use in all CWOs and in many public libraries.

Response

In the past, the field offices have experienced some difficulties in receiving Medi-Cal bulletins and other information from the fiscal intermediary due, in part, to the fact that the fiscal intermediary is unable to mail bulletins to the field offices prior to mailings to providers. Internal mail systems in the larger field offices also can create delays. The Field Services Section is working closely with the Procurement Project to improve the situation under the new Computer Sciences Corporation (CSC) contract.

In August 1978, the Eligibility Branch reinstituted the system of numbering letters going to all CWDs. Manual revisions and MCAC letters have always been numbered. This system should help to assure that CWOs receive all appropriate Medi-Cal materials.

Informational brochures describing the Medi-Cal program, services available, etc., are available in all CWOs; such information may also be obtained by telephone in all counties. During the application process, applicants are informed of services available, their rights and responsibilities as Medi-Cal beneficiaries, etc. Applicants are also told that copies of Medi-Cal and DSS regulations are available for use in the welfare department.

5. Treatment Authorization Request (TAR) System

Recommendations

It is recommended that the 20 sets of criteria currently under development be completed and issued to the field office medical consultants as soon as possible, and that work begin immediately on establishing additional sets of criteria. It is further recommended that current policy statements and guidelines regarding TARs, as well as criteria sets as they are established, be supplied to providers. Finally, some source of information, preferably for telephone calls, should be established to provide information to providers and recipients regarding the scope of Medi-Cal benefits.

Response

Twenty-two (22) medical criteria sets have been drafted including the most common or controversial surgical admissions, plus a criteria set on terminal care, and a set of criteria covering hospital admissions for mental illness.

These drafts have been received by the medical consultants in the field offices, by certain provider organizations, and by the County Mental Health Directors Conference.

These guidelines (criteria) are now being finalized and will be established by regulation. Consultants will use these criteria as a basis for their review of treatment requests.

Currently, policy statements are made available to providers through the Medi-Cal bulletin. The above criteria will also be made available when established in regulation.

Providers and recipients presently receive telephonic and written information as needed regarding the Medi-Cal scope of benefits through the Benefits Branch and other units within the Department.

6. Provider Access

Recommendations

It is recommended that the State and Federal Governments work together to determine the extent of the provider access problem and explore possible solutions. The current fee schedule should be reviewed, as well as procedures for processing claims and for providing guidance to physicians regarding coverage and proper submission of claims.

Response

DHS would be pleased to explore jointly with HEW possible solutions to the problem of access to care. We believe that to the extent we are able to move forward with the Medi-Cal initiatives effort, access problems will be diminished. We also would note that the Department continuously reviews fee schedules and conducts rate studies. Because of the fiscal constraints under which the Medi-Cal program is now operating, only a limited amount of money is available for provider rate increases, and those must be distributed to provider groups whose fees are the most inequitable.

Regarding the review of claims processing procedures: First, under the new contract with CSC, all claims processing procedures must undergo acceptance testing before that component of the system is accepted by the State. Once CSC is fully operational, DHS will continuously monitor the claims processing system to assure that it conforms to the State's monitoring plan. A new feature of the CSC contract makes available to each provider a claims processing manual which will be updated through provider bulletins on a regular basis. Training will be provided to all providers throughout the State to orient them to the new system.

7. Supplemental Appropriations

Recommendations

It is recommended that the State take whatever measures necessary to approve a more realistic Medi-Cal budget so as to avoid cost overruns and the subsequent need for a supplemental appropriation.

Response

The Department, at this writing, is not contemplating a cost overrun of the current 1978-79 budget. We believe that improvements in our fiscal forecasting system have contributed to this, although there are also some apparent anomalies in utilization patterns that are occurring. In any event, we are continuously striving to improve the accuracy of our forecasting system to avoid cost overruns.

8. Field Office Management Reviews

Recommendation

It is recommended that the schedule for management reviews of Medi-Cal field offices be reestablished on an annual basis.

Response

Review of field offices was initiated in September of 1978. Nine of twelve field offices were reviewed prior to December 1, 1978. At that time assignments relating to the new fiscal intermediary temporarily interrupted visits to the three remaining offices. With the anticipated hiring of three new physicians between July 1 and September 1979, it is anticipated that field reviews will resume in the fall.

9. Medi-Cal Cards

Recommendations

It is recommended that DHS again review the required use of sticky labels, with particular consideration given to use of the Recipient Eligibility History File as primary proof of eligibility.

Response

The Department agrees in theory that it would be advantageous to use the Recipient Eligibility History File as the primary proof of eligibility. However, in light of the enactment of Proposition 13 and the necessity to direct maximum state resources toward interim assistance to local government, the Administration has decided that the funding cannot be made available to absorb the costs of a claims processing system which would not require labels.

10. Transportation

Recommendation

It is recommended that the State take over fiscal responsibility and make specific payments for all transportation needs.

Response

California's state plan, submitted on March 28, 1974, was approved by HEW on August 28, 1975. Our Action Transmittal No. 76-14 to update the plan concerning the provision of necessary transportation and the methods used (3.1(c)) was submitted on December 1, 1976, and was approved on March 2, 1977.

The state plan does not require provision for all transportation to and from all providers of service. Rather, by interpretation and as outlined in Title 22, California has chosen to provide medical transportation for recipients to and from needed medical care by ambulance and/or other medical transportation providers when transport by ordinary means of public or private conveyance is medically contraindicated. Medical transportation by passenger car, taxicab, or other forms of public conveyance are specifically excluded by California Administrative Code, Title 22, Section 51151.

We believe that necessary transportation via the above methods is a responsibility of social service programs and is more appropriately provided for through public assistance cash grants, Title XX funds for mandated programs, volunteer-community agencies, county programs, friends, and relatives. The point can also be made that the Medi-Cal maintenance need amount is intended for all necessary expenses -- food, clothing, housing, and transportation.

Section C
Eligibility

1. Transfer of Property

Recommendation

Absent pertinent changes in its Title XIX program or in Title XVI, California should amend its program to eliminate the "transfer of property" restrictions it imposes on the aged, blind, and disabled MN.

Response

Response appears under recommendation 3.

2. California's "Special Deduction" Allowed to the Aged, Blind, and Disabled MN

Recommendation

Under current federal law and regulation, the State must establish procedures to ensure that claims for federal financial participation (FFP) are limited to maintenance levels calculated on the basis provided in 42 CFR 435.1007.

Response

Response appears under recommendation 3.

3. Categorically Needy Coverage of the Aged, Blind, and Disabled Receiving SSPs or in Medical Institutions (or intermediate care facilities (ICFs)): the 300 Percent Gross Income Limit

Recommendation

The State must establish procedures to assure that claims for FFP are limited per 42 CFR 435.230, 42 CFR 435.1005, and 42 CFR 435.1006.

Response (to recommendations 1, 2, and 3)

We have previously communicated our position and legal arguments on these issues to Region IX and have enclosed copies of these communications for your convenience. In our November 17, 1978 correspondence to your office, we requested that the assessment report include the following points:

a. For issues on which you have heard our legal arguments, a statement as to your view of the validity of those arguments; and for those arguments you consider invalid, your conclusions as to why you consider them invalid.

b. Where valid legal arguments exist on both sides, an explanation of the policy, as opposed to legal, bases for HCFA's position.

c. In areas where there is not a legal question, an acknowledgment of the philosophical bases or practical reasons for the existence of California's policy.

d. An identification of those areas in which the disagreement is over the process of determining eligibility rather than over the results of the determination.

We were disappointed to see that these points were not addressed in the report.

California is supportive of the proposed federal legislation on transfer of property and would appreciate being informed regarding the status of those legislative proposals.

4. California's Treatment of Parental Income and Resources Available to Children Under 21 in Family Groups Living Together When Making AFDC-Related MN Determinations

Recommendation

The State must amend its program to conform with 42 CFR 435.712 (a) and (c), 435.811, and 435.831 (c).

Response

We would like the report to indicate that our treatment of parental income and resources with respect to eligibility determinations for 18 to 21-year-olds and minors applying for "sensitive services" is founded in state statute. Legislation has been introduced which would bring our program into substantial conformity with federal regulations regarding treatment of parental income and resources available to children aged 18 to 21; however California strongly feels that the right of privacy for minors applying for sensitive services (drug abuse, venereal disease, family planning, etc.) must be protected. Considering the income and resources of the parents of these children when determining their Medicaid eligibility denies them this right.

5. Fair Hearings

Recommendation

If HEW does not change 45 CFR 205.10 (a) (5) (iii) to permit a year to appeal, then the Regional Medicaid Office should initiate compliance proceedings to enforce the 90-day limit on appeals.

Response

As indicated in the findings, state law permits one year in which persons may request a fair hearing and California is under court order to afford individuals this one-year period. It should be noted that legislation has been introduced which would limit the filing period to that stated in federal regulation.

6. Restriction on Application of Prior Month Medical Bills in Determining Share of Cost

Recommendation

The State should amend its policy to conform to federal policy in this area.

Response

We would like the findings to reflect California's position on this issue which is: California permits only current month medical expenses to be applied toward meeting the current month's share of cost. This is based upon 42 CFR 435.831 (c) (2) which states "the agency may set reasonable limits on the amounts of incurred medical expenses to be deducted from income". We feel that a "reasonable limit" is established by limiting the amount to those expenses incurred during the current month. We feel that the policy described in the Medicaid Eligibility Manual is not only difficult to administer but also encourages fluctuating eligibles to not pay medical bills during periods of ineligibility so they may use those debts to meet their share of cost during months of eligibility. We do not feel this is in keeping with the basic intent of the Medicaid program which is to assure that eligible individuals receive necessary medical treatment which they cannot afford to purchase.

7. Application of SSI Budgeting Methodology

Recommendation

The State should amend its program to conform to 42 CFR 435.822.

Response

Federal regulation 42 CFR 435.822 requires that "If both spouses apply or are eligible as aged, blind, or disabled and cease to live together, the agency must consider their income and resources as available to each other for the first six months after the month they cease to live together." It is California's policy to not consider their income and resources as available to each other during this time period. In the majority of situations, the eligibility determination produces the same result. In those instances in which eligibility would be affected during the first six months of separation, under the federal regulation, one spouse could elect not to make application and then both spouses' income and resources would not be considered as available to each other. We feel our policy is more efficient and in keeping with the basic tenets of the SSI budgeting methodology.

8. Retroactive Spenddown of Resources

Recommendation

Further discussion should be conducted with the State regarding this practice.

Response

Resource appears under recommendation 9.

9. Prospective Conditional Eligibility

Recommendation

Further discussion should be conducted with the State regarding this practice.

Response (to recommendations 8 and 9)

We feel the report should also reflect our position that our policy regarding retroactive spenddown of resources affords persons the same benefits as prospective conditional eligibility and that we feel our policy is easier to administer. We look forward to discussing this further.

10. Monitoring of Four-Month Continued Coverage Cases

Recommendation

The State should initiate continuing monthly review of earnings and hours of employment criteria of this group. The State should terminate coverage of the Zero Base Grant group under the four-month continuing coverage provision.

Response

The report should reflect that the State is currently taking action to comply with this recommendation.

11. Areas 11 Through 19

(No recommendations were made.)

Comment

It would appear appropriate that some of the statements made in other portions of the report be reconciled with these findings, specifically county staff reaction to the State's eligibility manual and to DHS dissemination of policy changes in the Medi-Cal program. (See findings 13 and 16.)

[redacted]

6) 445-1243

NOV 13 1978

Mr. Lawrence L. McDonough
Regional Medicaid Director
Department of Health, Education,
  and Welfare
Health Care Financing Administration
Regional Office
50 United Nations Plaza
San Francisco, CA 94102

Dear Larry:

This is in response to your letter of September 29, 1978 in which you requested our position on four areas in the Medi-Cal program which you believe conflict with Federal Medicaid eligibility requirements.

Our position on transfer of property restrictions imposed on the aged, blind, and disabled medically needy persons was explained in a previous letter to you from Richard Koppes of my legal staff. The other issues are discussed below. They are numbered corresponding to the numbering used in your letter.

1. California's transfer of property restrictions

   See Department of Health Services letter of October 3, 1978 on this subject.

2. "Special Deduction" allowed to the aged, blind, and disabled medically needy

   Title XIX of the Social Security Act defines medically needy persons as those whose income and property exceed the amount allowed to the categorically needy but are insufficient to meet their medical needs. Section 1902 of Title XIX further requires that financial criteria for medically needy correspond to the criteria for the appropriate categorically needy group. Federal regulation 42 CFR 448.3 (b) (1) provides that only available income and resources be considered in determining eligibility and that income and resources must be reasonably evaluated. Additionally, 42 CFR 448.3 (c) (2) states there must be a flexible measurement of available income.

   California's "special deduction" is in keeping with these requirements. It would be unreasonable and inflexible to consider as income available to meet medical needs under the medically needy program an amount of income, which for the corresponding categorically needy program, is allowed for shelter, food, and clothing.

   We believe that such an unreasonable situation is certainly not required by Title XIX statute. We further believe that the "special deduction" is in keeping with current 42 CFR wording, in that the "special deduction" exempts a person's income from having to be used for medical care to the same degree that the SSI/SSP program in California makes such an exemption.

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SSI/SSP rules provide in effect that an SSI/SSP recipient's income, from the appropriate Medicaid maintenance need level up to the appropriate SSI/SSP payment level, is exempt from being considered available for medical care; if it were not so exempted, the person would have a Medicaid spenddown. The "special deduction" provides exactly the same income exemption, for Medicaid spenddown computation purposes, to the corresponding California medically needy population. This is in keeping with 42 CFR Section 448.3 which states that for aged, blind, and disabled medically needy determinations, the income deductions and exemptions applicable to the SSI and/or SSP program, whichever are higher, must be allowed.

California's "special deduction" simply ensures that the aged, blind, and disabled medically needy population retains an amount of monthly income equal to the corresponding categorically needy population. As you are aware, without this income disregard, a small increase in personal income which renders an aged, blind, or disabled person ineligible as categorically needy would result in a medically needy spenddown disproportionate to the increase in income.

3. Categorically Needy Coverage of the Aged, Blind, and Disabled Receiving State Supplementary Payments or in Medical Institutions (or ICF's): The 300 percent Gross Income Limit

In view of the "special deduction", this issue is currently moot. California extends the same Medicaid benefits to both its categorically needy and its categorically linked medically needy. Persons receiving SSP, whose gross income is in excess of 300 percent of the SSI payment level, receive the same degree of entitlement to Medicaid-paid care as persons separately determined eligible as medically needy. If a separate medically needy determination, including application of the "special deduction", were completed for these persons, they would not have a spenddown. Since it is more cost-effective to provide Medicaid coverage on the basis of the SSP eligibility determination instead of requiring a separate medically needy determination, California has chosen this alternative. We believe this is in keeping with 45 CFR 206.10 (a) (11) as noted below.

4. Failure to consider parental income and resources available to children under 21 in family groups living together when making AFDC-related medically needy determinations

A and B. Medicaid coverage for 18 to 21 year olds living with their parents (both non-categorically related and AFDC related).

We question the applicability of 42 CFR 443.3 (b) (5) (i) with respect to children who live in the same house as their parents, but have demonstrated financial independence. For example, is it the intent of federal regulations to consider parental income available to a 20 year old child who has been employed and self-supporting and has been paying his parents room and board since age 18? We believe that 42 CFR 448.3 (b) (5) (i) can and should be interpreted so that persons under 21 who meet their own financial needs are not considered dependents of their parents regardless of living arrangements.

Regarding persons under 21, who are living at home and financially dependent on their parents, the Department has drafted proposed necessary State enabling legislation which would hold parents financially responsible for medical costs of children up to age 21 who are residing in the parents' home. Parents with children under 21 should be exempt from financial liability in those instances where the child can demonstrate financial independence.

C. Inclusion of voluntarily excluded person's medical expenses in meeting the spenddown liability.

(1) Voluntarily excluded parents and spouses.

Program staff are currently in the process of amending Medi-Cal regulations so that the incurred medical expenses of voluntarily excluded persons whose income and resources are considered available in the eligibility determination will be used toward meeting the spenddown liability.

It should be noted, however, that in practice, only parents with no medical expenses choose to exclude themselves from the assistance unit.

(2) Voluntarily excluded children.

Our position is that the medical expenses of voluntarily excluded children cannot be used toward meeting the spenddown liability of the assistance group. Federal Regulation, 42 CFR 448.3 (b) (iii), limits financial responsibility to spouse for spouse and parents for children. In addition, 42 CFR 448.3 (b) (5) (iv) states in part, "Such medically needy levels shall be based on the total family size of eligible and ineligible relatives whose income or resources are (or can be) considered available to the assistance unit after deducting all such relatives' incurred medical expenses." Since an excluded child has no responsibility to support either the parents or siblings, the child's income or resources cannot be considered available to the assistance unit. Therefore, any medical expenses incurred by the child cannot be used toward meeting the spenddown of the assistance group. Usually a child is excluded because he/she has separate property which would render the entire family ineligible or separate income which would cause the spenddown to be considerably higher.

D. Children in need of "sensitive services".

California law permits minors to receive certain medical services without parental consent. These services, such as treatment for drug addiction, venereal disease, sexual assault, etc., are sensitive in nature. The requirement of parental consent or parental financial responsibility would deter minors from obtaining necessary medical treatment.

Federal Regulation 45 CFR 206.10 (a) (11) provides that, with respect to Title XIX, policies and procedures shall assure that eligibility for medical assistance shall be determined in a manner consistent with simplicity of administration and the best interests of the applicant or recipient. California feels that it is in the minors' best interest to provide medical assistance for sensitive services without regard to parental responsibility. This is because, in a great many cases, children will forego needed medical care rather than face the emotional trauma of telling their parents of their particular medical condition. In some cases, parents will not cooperate in seeing that necessary care is provided and paid for. In all cases, the medical conditions involved are those which are likely to have long-lasting, debilitating effects on the patient if effective treatment is not received. For some of those conditions, such as venereal disease and drug addiction, the consequences of non-treatment may extend to many persons other than the patient.

Under California's sensitive services program, Medicaid coverage is restricted to only sensitive services. These minors receive special identification cards and the only claims that will be paid without regard to parental resources are those which relate to sensitive services.

I trust this clarifies California's position on these issues. I look forward to resolving these issues to the mutual satisfaction of our respective agencies. I believe the legal framework of the Medicaid and Medi-Cal programs provides sufficient latitude so that we can make the program management decisions needed for that resolution. My staff and I look forward to completing the process with you and your staff.

If you have any questions regarding this response, the Policy Section of the Eligibility Branch is available at (916) 445-1797.

Sincerely,

Original Signed by
BEVERLEE A. MYERS

Beverlee A. Myers
Director

21399

ATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY
EDMUND G. BROWN JR., Governor

EPARTMENT OF HEALTH
744 P STREET
CRAMENTO, CALIFORNIA 95814
916) 322-6996

October 3, 1978

Lawrence McDonough
Acting Regional Medicaid Director
Dept. of Health, Education & Welfare
Health Care Financing Administration
Regional Office
50 United Nations Plaza
San Francisco, CA 94102

Dear Mr. McDonough:

This letter is to advise you of the Department of Health Services' position on whether the Department is out of compliance with Federal law as a result of the state requirement that eligibility be denied if an applicant or recipient has transferred property without adequate consideration to establish eligibility.

It is our position that this state requirement does not conflict with the Federal regulations. Section 1902(f) of the Social Security Act allows the Department to continue to impose more stringent eligibility criteria that were in effect under the Medi-Cal program on January 1, 1972. Since our transfer of property criteria were in effect as of that date, the Department is entitled, pursuant to section 1902(f) to continue to apply those criteria. Furthermore, we believe that our position is buttressed by a similar provision in 42 CFR 233.10(a)(1)(ii) which allows the state to impose more stringent eligibility criteria than those in the Social Security Act.

Federal law requires the state to apply equal eligibility criteria to all Medicaid recipients. The Department, however, imposes the transfer-of-property criteria on all Medi-Cal recipients except aged, blind and disabled SSI recipients. We have contracted with the Social Security Administration to determine Medi-Cal eligibility of all aged, blind, and disabled SSI recipients. Under this arrangement, SSA has been determining eligibility of these recipients by applying Federal eligibility criteria, which do not include transfer-of-property provisions. We are investigating the possibility of a conflict between the Federal requirements and the Department's practice of applying more lenient eligibility criteria to these SSI recipients.

We are also exploring the possibility of eliminating any conflict with Federal law by developing a referral process for all SSI recipients who have transferred property. Under such a system, SSA would refer to the Department for determination of eligibility all SSI recipients who indicate on their application form that they have transferred property within the two years prior to the application. The Department would then determine the eligibility of these SSI recipients by applying our transfer-of-property criteria. We would then be applying the criteria equally to all Medi-Cal recipients and would be in full compliance with the Federal regulations.

As per your request, we are enclosing a copy of the answer to the complaint that the Attorney General's office has filed on behalf of the Department in the *Dawson* lawsuit. Also enclosed for your information is a draft memorandum citing most of the statutes and regulations pertinent to this issue.

If you have any questions about the Department's position on this matter, please contact Marian King at (916) 322-6996.

Sincerely,

RICHARD H. KOPPES
Chief Counsel
Office of Legal Services

RHK:fc

Enclosures

cc: Bill Lockett
✓ Doris Z. Soderberg
Richard Magasin
Deputy Attorney General
Los Angeles

916) 445-1797 January 26, 1977

Mr. Charles W. Goady
Regional Commissioner
Social and Rehabilitation Service
Department of Health, Education,
  and Welfare
50 United Nations Plaza
San Francisco, CA 94102

Dear Mr. Goady:

You mentioned in your December 29, 1976 letter that you would like my comments concerning two possible compliance issues which have been identified by your staff in its review of our new Medi-Cal eligibility regulations.

The first issue, which is covered by Section 50555.4 of the new regulations, concerns the "Special Deduction" allowed for aged, blind, or disabled (ABD) medically needy (MN) persons.

I have consulted my legal staff on this question and they inform me that the "Special Deduction" does not appear to be in conflict with federal law or regulation for several reasons.

First, federal regulations (45 Code of Federal Regulations (CFR) 248.3 (c) (1)) state that the income maintenance level for two must be at the Supplemental Security Income/State Supplementary Payment (SSI/SSP) payment level to the extent that federal financial participation (FFP) is available. Additionally, this section does not appear to rule out different income maintenance levels for persons linked to different cash programs. Federal regulations (45 CFR 248.4 (b)) state that in order to obtain FFP, the income maintenance level must be 133 1/3 percent of the payment level allowed under the Aid to Families with Dependent Children (AFDC) program, except that in the case of a single person living alone, the income maintenance level must be reasonably related to the AFDC payment level for two persons. It is the opinion of my legal staff that the highest SSI/SSP payment level for a single person bears a reasonable relationship to the AFDC payment level for two.

Second, federal law defines MN persons as those whose income and property exceed the amount allowed to the categorically needy but are insufficient to meet their medical needs. Federal law and regulation state that only income which is actually available may be considered. Aged, blind, or disabled persons with income below the SSI/SSP payment level are considered to be categorically needy. Therefore, it would be in conflict with federal law and regulation in both intent and practice to set the ABD Medi-Cal allowable income amounts below the combined SSI/SSP cutoff point for determining which persons have insufficient income to meet their basic needs. It is the opinion of my legal staff that any income up to the SSI/SSP payment level must be considered unavailable to meet medical expenses of ABD persons since, under Title XVI, that amount is reserved for basic living expenses.

Third, in determining Title XVI eligibility, federal regulations (20 CFR 416.1145 (b) (2) and 20 CFR 416.1151) require SSP payments to be disregarded. Title XVI federal regulations (45 CFR 248.3 (c) (3)) require that Medi-Cal eligibility be determined using all Title XVI disregards. Therefore, in determining Medi-Cal eligibility, an amount equal to the SSP payment must be disregarded. It is the opinion of my legal staff that for aged, blind, or disabled persons, the intent of federal regulations is to disregard an amount equivalent to the SSP amount payable to Title XVI eligibles, in addition to any other disregards allowed, even if no actual cash assistance is paid.

For the reasons stated above, it is the position of the Department of Health that Section 50555.4 does not conflict with federal law or regulation.

The second issue you cite in your letter refers to Section 50553.1 of the new Medi-Cal eligibility regulations. According to the AFDC State Plan, the $30 + 1/3 disregard, while not used in determining initial eligibility for AFDC, is used to determine continuing financial eligibility for AFDC eligibles who become employed. 45 CFR 233.20 (a) (11) (ii) (b) states that the $30 + 1/3 is only allowed in determining financial eligibility if the family was receiving an AFDC cash grant in one of the four previous months. The disregard is applied to determine financial eligibility for Medi-Cal in the same manner in which it is applied in the AFDC program — that is, it is applied only if the person was in receipt of a cash grant in at least one of the four months immediately preceding the month in which the disregard would be applied. For this reason, it is the position of the Department of Health that application of the $30 + 1/3 disregard does not conflict with federal law or regulation.

I appreciate your contacting me concerning these possible compliance issues. My staff will be available to work with you toward a resolution of the issues you have raised. Also, I have enclosed a copy of our new Medi-Cal Eligibility Manual, which includes a reprint of the recently filed eligibility regulations. Please contact Mr. Wade J. Williams, Chief, Medi-Cal Eligibility Section, (916) 445-1797, if you have any questions relating to these matters.

Sincerely,

/S/

Lee Helsel
Deputy Director for
Medi-Cal Division

Enclosure

CG:jg/3
5331

DHEW STATE ASSESSMENT - PROVIDER RELATIONS SECTION

SECTION D

I. Recommendation

DHS should identify a component to be more responsible for ongoing relations with health care providers in the State.

Response

The Department agrees that some careful analysis of the way in which we manage provider relations is merited. We do not, however, agree that it is realistic to designate a single organizational unit as a focal point for this activity for reasons outlined below:

1. The establishment of a provider relations unit and publicizing its existence within the provider community would create an unmanageable workload in the Department during a period of time when staff shortages are already in a critical state. We are operating a program which includes thousands of providers. It is far more efficient and cost effective for DHS to have communications from providers channeled through already existing external organizational structures such as the California Medical Association, California Hospital Association, etc.

2. A second disadvantage of centralized provider unit would be one of duplication of effort. There are several existing units whose ongoing activities require frequent interface with providers both on an individual and organizational basis. Medi-Cal Benefits Branch, for instance, might be contacted by an organization for interpretation of a regulation. Rate Development Branch would be requested by a surgical center to assist in developing a global billing fee.

   It would seem wasteful to have both a highly skilled program staff who could respond to such technical problems as well as maintaining a specialized unit with equal expertise in all areas of provider relations. We can, however, review DHS provider relations activities in terms of policy development, day-to-day operations, and assistance with individual problems.

II. Recommendation

DHS should review with provider associations the current membership of the Medicaid Advisory Committee to assure that both health care providers and consumer groups are adequately represented on the Committee.

Response

DHS is currently examining with a view toward expanding the structure and role of its Medicaid Advisory Committee (the Advisory Committee on Health and Medical Care Services.) While some providers may feel their views are not represented on the Committee because of the fact that provider organizations per se do not participate, DHS believes provider representation is adequate. In fact, DHS chose deliberately not to structure the Committee so that specific provider organizations

would be represented due to a concern that such organizations would attempt to control or dominate the Committee. The following types of providers are members of the Committee:

- Two Prepaid Health Plan Administrators, one of whom is also an optometrist
- A practicing OB/Gyn
- A hospital/clinic administrator
- A county health officer who is also a physician
- A public health professor who is also a physician

In addition, the Department is confident that it has effectively opened and maintained active dialogue with the various provider organizations in both day-to-day operational areas and policy development and change. It has become routine procedure for the Department to consult with provider organizations in advance prior to making any minor or major program changes. Draft regulations are frequently discussed with provider organizations to obtain comments before they are finalized. Department staff frequently attend provider organization committee meetings, and the Director has participated as guest speaker at several professional association meetings.

We maintain the informal communications network described above is adequate and effective and obviates the need for formal provider organization representation on the advisory committee.

III. Recommendation

DHS should continue to promote the participation of the health care provider community in the development of the State's Medicaid program.

Response

In addition to the evidence that DHS is actively involving providers in its Medi-Cal policy development activities as outlined in the response to the previous recommendation, we would add that the Department has recently established a new committee which has heavy provider representation. This committee, the Special Committee on the Future of Publicly Funded Health Services in California, was established in the wake of the passage of Proposition 13 to review and evaluate:

1. The impact of Proposition 13 and SB 154 on publicly funded health services in California;

2. Alternative configurations for the delivery of public health environmental health and personal health services;

3. Public-private and State-county roles, responsibilities and interrelationships for the delivery of health services;

4. Alternative levels of funding, sources of revenue, and methods of financing publicly funded health services.

While the above Committee involves providers in a role much broader than the Medi-Cal program, we have also recently established an advisory committee to consult with us on the conversion of the fiscal intermediary contract from Medi-Cal Intermediary Operations to Computer Sciences Corporation. This Committee is composed exclusively of provider organization representatives including the California Medical Association, California Association of Health Facilities, County Supervisors Association, and the California Optometric Association.

IV. Recommendation

DHS should regularly meet with representatives of all health care provider groups to inform them of the progress being made on the changeover in fiscal intermediaries and any problems that may arise during the transition period.

Response

As outlined in our response to Item III, the Department has established regular meetings with major provider associations for the discussion of design issues and potential problems with regard to the fiscal intermediary conversion. The association's representatives act as conveyors of information to their provider communities regarding the progress of conversion.

V. Recommendation

DHS should conduct a study to accurately determine the actual health care provider participation rates in all geographical areas of the State.

Response

The Department has conducted two such studies, both this year and last, in connection with provider reimbursement rates. In 1976, a new statewide reimbursement method was established to pay for Medi-Cal physician services. Chapter 1204, Statutes of 1976 (AB 4242) requires the Department to review annually reimbursement rates as they affect physician participation in the Medi-Cal program. The first report was published in January 1978, and this year's report was to be submitted in February to the Legislature. Findings from these reports do not demonstrate any significant change in the provider participation rates in specific geographical areas.

VI. Recommendation

DHS should negotiate with existing PSRO's in the State to enter into a memorandum of understanding for Title 19 medical reviews.

Response

DHS is negotiating MOU's with PSRO's but doubts that this specious recommendation will resolve provider allegations of arbitrary and inconsistent administration of the State's Medi-Cal utilization review system.

Utilization review systems are, after all, operated by people. We are at a loss as to where we might recruit employees who could say "no" to inappropriate and unnecessary services who would not be viewed by providers as being arbitrary and inconsistent. In fact, the problem may be exacerbated when evolving from a utilization review system with 12 focal points (number of Medi-Cal field offices) to 28 focal points (number of PSRO areas), the latter having different utilization controls and criteria for each area, sometimes applied differently to hospitals across the street from each other. Nevertheless, DHS is negotiating MOU's with PSRO's and has kept DHEW informed of progress and problems.

VII. Recommendation

DHS should work with DHEW to develop and implement a uniform billing form that would be mutually acceptable.

Response

The Department was involved in extensive negotiations with DHEW on implementation of UB-16. However, DHEW requirement to use UB-16 for both inpatient and outpatient services could not be accommodated due to inadequate space for all data elements normally required by California for outpatient claims. It was finally agreed to not be involved as a test site for UB-16. Currently, we are working with CSC to develop an inpatient only claim form based on the CHA version of the UB-16 now in use. We will include both CHA and the California Health Facilities Commission in developing the claim form for hospitals and fully expect to reduce provider Medi-Cal billing complexity and expense.

VIII. Recommendation

DHS should form an Ad Hoc Reimbursement Committee composed of both state agency and health care provider association representatives, to consider and recommend possible courses of action to ameliorate provider reimbursement problems.

Response

The Department does not feel the need to establish such a committee. We believe the communication channels have been sufficiently open and accessible to providers who wish to voice their concerns over reimbursement rates and we have found that they have not hesitated to utilize these mechanisms. Departmental staff periodically conduct rate studies and share their findings with provider organizations.

We admit provider reimbursement levels do not meet provider expectations in most cases. We do not, however, predict major relief in the foreseeable future due to the current State budget constraints. Rate increases were included in the current year's budget, but then were eliminated due to the passage of Proposition 13. We believe reimbursement rates granted providers should reflect other increases granted by the Legislature in this day of fiscal restraint.

IX. Recommendation

DHS should establish Ad Hoc Medicaid Provider Reimbursement Committee mentioned earlier as a recommendation under finding No. VIII. In addition, DHS should continue its long-standing negotiations with DHEW to develop the terms and conditions of common audits for both Medicare and Medicaid programs.

Response

It is not necessarily true that "Common Title XVIII and XIX audits would lead to lower hospital administrative cost" as stated in Item No. 6, page 6. It is true, however, that it would lead to lower State/Federal administrative cost. On November 1, 1978, the Director and others met with regional staff to establish the basis for a common audit prototype; general agreement was reached as to the methodology to be employed, the general extent, and the criteria. Federal representatives were to discuss this project with the intermediaries (for Medicare) and subsequently arrange for a meeting of all parties concerned for more detailed development.

X. Recommendation

DHS should develop and distribute Medi-Cal provider manuals to all health care providers in the State. In addition, a section of the manuals should enumerate and explain Federal and State laws and regulations on program integrity issues.

Response

The State's fiscal intermediary contract with Computer Sciences Corporation (CSC) requires CSC to develop provider manuals, subject to DHS approval.

The pharmacy manual is currently being revised by DHS and does provide copies of applicable Federal and State laws/regulations. We assume future manuals will do likewise.

XI. Recommendation

DHS should regularly make known to provider groups those channels already established for referral of suspected recipient and provider fraud and abuse.

Response

The Department currently employs medical staff who meet regularly with provider groups. One purpose for these meetings is to inform provider groups of our established methods for referral of suspected recipient and provider fraud and abuse. In the past, the Department has issued Provider Bulletins dealing with the subject and will continue to issue them on an as-needed basis. The Department also issues to all Medi-Cal providers a quarterly list of suspended providers.

Section E
Reimbursement

I. Hospital Reimbursement

1. Recommendation

DHS should continue its efforts to develop an alternative hospital reimbursement method designed to maintain a high quality of care as well as efficiency and economy.

Response

The Department will continue its efforts to develop an alternative hospital reimbursement method. We are appealing the district court ruling that our proposed system violates federal law.

II. Reasonable Charge Determinations (Noninstitutional) Providers

2. Recommendation

DHS should compare maximum reimbursements between the Medicare and Medi-Cal programs to identify any procedures for which the Medi-Cal program is paying more than Medicare. DHS should make this comparison whenever either Medicare or Medi-Cal payment rates are updated. If Medi-Cal is currently paying more than Medicare for a given procedure, DHS should establish controls in the Medi-Cal claims processing system to limit reimbursement to the Medicare rate or less.

Response

This recommendation is based on the federal regulation establishing Medicare payments as the upper limits to Medicaid payments. This regulation, 42 CFR 447.341, contains two general concepts on upper limits. First, Medi-Cal may not pay an individual practitioner more for any given service than Medicare program pays that practitioner. Second, Medi-Cal may not pay any practitioner more than the Medicare prevailing reasonable charge. DHS has not made all the comparisons, since the cost of comparing and equalizing Medi-Cal and Medicare payments would probably exceed any savings generated. That is, since there are about 40,000 physicians in California and about 5,000 procedures listed in the 1974 Relative Value Study (RVS), DHS would have to make 200,000,000 comparisons. Given that Medi-Cal conversion factors are so much lower than those for Medicare (see table below), the only possible rate reductions will be for a few isolated individual practitioners rather than for large groups of providers. Therefore, the costs of the exercise probably outweigh the savings.

Medicare Conversion Factors		Medi-Cal Conversion Factors
Medicare	$ 1.00	$ .64/ .69 (primary care)
Pathology	$ .40	$ .28
Radiology	$ 5.00	$ 3.00
Anesthesia	$14.00	$ 11.00
Surgery	$50.00	$29.25/37.50 (maternity care)

Additionally, two misstatements appear in the HEW report. Data for Medi-Cal conversion factors is from claims paid experience for December 1975 through February 1976, not from October to December 1973. Payments rates were updated in July 1977 for pathology services, not for anesthesia.

III. Reimbursement for Drugs

Recommendation

DHS should take whatever steps are necessary to reinstate audits of pharmacies.

Response

DHS is working with interested provider groups to develop acceptable audit procedures, including a sampling plan and error ratio estimator. HEW assessment contains some misinformation, however. Pharmacies, as well as physicians, may request prior approval for non-Formulary drugs. The Department has no requirement that pharmacies bill Medi-Cal for no more than the pharmacy's cost of the drug plus the allowable dispensing fee. Instead, the Department requires pharmacies to charge Medi-Cal no more than the pharmacy's charge to the general public.

IV. Home Health Agencies

4. Recommendation

For home health agencies, DHS should compare Medi-Cal and Medicare rates and, for those Medi-Cal rates that are now higher than Medicare, establish controls to limit Medi-Cal reimbursement to the Medicare rate.

Response

DHS will make such comparisons and establish controls where warranted.

V. Long-Term Care Reimbursement

A. State Plan Amendment

Recommendation

DHS should submit a State Plan amendment regarding long-term care reimbursement which can be approved by HEW.

Response

It is our understanding, at this writing, that our State Plan amendment has been approved.

B. Retroactive Rates

Recommendation

DHS should develop an implementation plan to retroactively apply rates to effective date of approved State Plan amendment.

Response

A feature of an implementation plan such as the one suggested by HEW requires a policy decision by DHS management on the legality of making retroactive adjustments to program payments.

C. Automated System

Recommendation

DHS should continue use of electronic data processing (EDP) for rate setting calculations.

Response

We fully intend to continue use of EDP whenever cost effective.

D. Alternative Reimbursement Systems

Recommendation

DHS should investigate alternative reimbursement systems, with a view to recognizing quality of care in the reimbursement context.

Response

DHS will explore alternative reimbursement systems, as time and availability of staff permits.

VII. Provider Audits

9. Recommendation

DHS should continue working with Health Care Financing Administration (HCFA) and Medicare intermediaries to implement a comprehensive common audit system for all California hospitals.

Response

We intend to continue our efforts toward this objective.

Section F
EPSDT

General Comments

I. General Description

Page 1, Paragraph 2

The Branch does not actually "coordinate" data tracking, county welfare staff training, or the activities listed. It provides workshops and technical consultation in these areas. It also stimulates these activities and looks for them in the annual CHDP plans submitted by county programs.

Page 1, Paragraph 3

Contract counties do not receive the same State CHDP Regional Team consultation as do the noncontract counties. The Rural Health Division provides consultation to the contract counties.

II. Budgets

Page 2, Paragraph 2

The phrase "case management", in parentheses after the term "EPSDT units", is somewhat misleading. Case management is only one of the components of the EPSDT Functional Unit. Also, EPSDT Functional Units are matched at 75 percent FFP for salaries, travel, and training. Overhead is matched at 50 percent.

III. Informing

Page 5, Paragraph 6

Redetermination of eligibility for AFDC and Medi-Cal normally occurs once a year, not at three to six-month intervals as this paragraph indicates (except for Aid to Families with Dependent Children in Board Homes and Institutions (AFDC-BHI) redeterminations which are completed every six months). However, some counties may choose to notify Medi-Cal eligibles of the CHDP Program, by way of a brochure mailing, as often as every three to six months.

IV. Screening

Page 6, Paragraph 2

The statement, "a screen must occur within 60 days", is not completely true. The requested screen must occur within a reasonable period of time -- normally not to exceed 60 days or it must otherwise be accounted for, e.g., in instances where the appointment was not kept or the family changed its mind and did not want the service.

Page 6, Paragraph 3

The statement, "the Public Health Department is responsible for following up on all recipients to ensure that a child received the screen", is somewhat misleading. Usually this responsibility is assumed by the EPSDT Functional Unit (in conjunction with CHDP staff), and the unit may be located in the welfare department, the health department, or both.

V. Case Management

Page 7, Paragraph 3

EPSDT Functional Units may be located in the county health or welfare department, or in both. The two departments may provide different EPSDT functions. For example, the welfare department might provide intensive informing and referral to screening, while the health department might provide case management, and referral and follow-up to diagnosis and treatment.

Page 7, Paragraph 4

As previously stated, EPSDT Functional Units are funded at 75 percent and 50 percent, depending on the budget item -- not at 75 percent funding only.

VI. Finding: Inadequate Number of Children Screened

Pages 9-10

The first paragraph in this section contains several errors. To begin with, if one were to assume that the stated "eligible population" (1,525,747) and number of "screens" (124,688) were correct, then 8.2 percent, not "one" percent of the eligible population, was screened (i.e., 124,688 ÷ 1,525,747 x 100 = 8.2).

The stated number of reported screens (124,688) in 1968 is puzzling. For one thing, the monthly federal EPSDT report (SRS-NCSS-120) does not include the number of screens, but rather the number of individuals screened. The numbers of individuals screened and the numbers of screens reported in any given time period will differ, due to the periodicity of screens (e.g., a child under one year of age can receive as many as five screens). Since there is no federal report that contains the number of screens, it is assumed that the reported 124,688 figure refers to individuals screened, not to screens.

An additional problem concerns the specific time frame meant by the term "in 1978". On Table 1, prepared by the CHDP Branch, the numbers of individuals screened and reported on the monthly federal EPSDT report for three specific time periods that could have been meant by "in 1978" are shown: (viz., California's Fiscal Year 1977-78 (July 1, 1977-June 30, 1978); federal Fiscal Year 1978 (October 1, 1977-September 30, 1978); and calendar year 1978. In all three cases, the numbers reported differ from the number cited in the assessment. It appears, however, that federal Fiscal Year 1978 may have been intended.

The size of the Medicaid eligible population cited in the assessment (1,525,747) is also erroneous. As shown on Table 2, prepared by the Center for Health Statistics, the figure of 1,525,747 refers to the total CHDP "target" population figure for Fiscal Year 1977-78. CHDP's target population includes non-Medi-Cal as well as Medi-Cal persons. Footnote 2 on Table 2 includes the definition of the target poulation. The figure from Table 2 that represents the correct number of Medi-Cal eligible persons is 1,348,293.

The cumulative affect of the above errors results in a gross misrepresentation of the screening activity of California's CHDP Program. As shown on Table 3, prepared by the CHDP Branch, California is screening considerably more than the one percent of the eligible population cited in the assessment.

The statement that "California ranks 52nd out of the 53 National Medicaid jurisdictions for the total number of completed EPSDT screens" is impossible to address since no information is provided in the assessment that explains how the state rankings were derived. Surely this statement is not intended to be taken literally. A report recently published by HCFA shows that California ranks third out of 50 reporting National Medicaid jurisdictions in the number of complete EPSDT screens (see Table 4). What was probably intended by this statement is not the absolute number of EPSDT screens, but rather the rate or percent of EPSDT eligible persons that are screened.

Comparison of state EPSDT programs on the basis of screening rates would be absurd, however, if standard definitions of "screens" were not employed. Without standardization, these comparisons would suffer from the same shortcomings as those associated with "apples and oranges" comparisons. It is distressing to see such simplistic and meaningless comparisons being made without considering the varying scope, quality, and frequency of EPSDT screening examinations among the 53 National Medicaid jurisdictions.

Although California's screening rates are higher than indicated in the assessment, it is nevertheless true that many potentially reportable EPSDT screens are not being counted by the CHDP Program. One of the reasons for this has been the problem associated with complete and partial screens.

Federal reporting guidelines allow only the number of children who received a complete health screen to be reported. A complete screen is

Table 1
Number of Individuals Screened and Reported on Monthly Federal EPSDT Report (Form SRS-NCSS-120) Child Health and Disability Prevention Program

onth/Year	Reported Number of Individuals Screened [1]	State FY 77-78	Federal FY 78	Calendar 1978
Jul 77	6,611	120,990		
Aug 77	8,997			
Sep 77	10,045			
Oct 77	8,634		124,956	
Nov 77	10,062			
Dec 77	9,564			
Jan 78	9,946			130,206
Feb 78	8,703			
Mar 78	13,030			
Apr 78	13,360			
May 78	11,992			
Jun 78	10,046			
Jul 78	15,194			
Aug 78	8,003			
Sep 78	6,422			
Oct 78	6,525			
Nov 78	13,433			
Dec 78	13,552			

1. Includes only individuals who received a "complete" screen. A complete screen is one in which the child received all of the screening procedures and tests appropriate to his/her age and sex as defined in State CHDP regulations.

ce: California State Department of Health Services, Child Health and Disability Prevention Branch, May 1979

Table 2

ESTIMATED ELIGIBLE AND TARGET POPULATION
CHILD HEALTH AND DISABILITY PREVENTION PROGRAM
Fiscal Year 1977-78

COMMUNITY PROGRAM	TOTAL ELIGIBLE POPULATION[1]	TOTAL TARGET POPULATION[2]	MEDI-CAL PERSONS	NON MEDI-CAL PERSONS		
			Total 0-20 Years Old[3]	Total 0-6 Years Old[4]	State Funded[5]	Others[6]
ALL PROGRAMS	3,005,631	1,525,747	1,348,293	1,657,338	177,454	1,479,884
Non-Contract County Programs, Total	2,969,327	1,506,410	1,332,405	1,636,922	174,005	1,462,917
Alameda[7]	134,818	72,916	60,164	74,654	12,752	61,902
Berkeley City	9,934	5,134	4,182	5,752	952	4,800
Butte	15,936	9,455	8,305	7,631	1,150	6,481
Colusa	1,650	681	496	1,154	185	969
Contra Costa	76,328	35,372	31,844	44,484	3,528	40,956
Del Norte	a	a	a	a	a	a
El Dorado	7,226	3,458	2,768	4,458	690	3,768
Fresno	77,313	45,248	36,615	40,698	8,633	32,065
Humboldt/Del Norte	17,644	9,431	8,092	9,552	1,339	8,213
Imperial	15,135	8,554	6,511	8,624	2,043	6,581
Inyo	1,932	828	606	1,326	222	1,104
Kern	56,844	30,492	25,624	31,220	4,868	26,352
Kings	12,704	7,063	5,122	7,582	1,941	5,641
Los Angeles	1,029,886	564,027	532,118	497,768	31,909	465,859
Madera	8,685	5,353	4,362	4,323	991	3,332
Marin	19,656	5,903	4,494	15,162	1,409	13,753
Mendocino	9,643	5,537	4,840	4,803	697	4,106
Merced	21,285	12,092	9,690	11,595	2,402	9,193
Monterey	36,972	15,986	12,866	24,106	3,120	20,986
Napa	9,568	3,976	3,144	6,424	832	5,592
Orange	211,787	63,369	50,142	161,645	13,227	148,418
Placer	11,894	5,949	4,918	6,976	1,031	5,945
Plumas	1,961	978	871	1,090	107	983
Riverside	84,030	45,509	41,543	42,487	3,966	38,521
Sacramento	104,270	59,111	54,137	50,133	4,974	45,159
San Bernardino	114,801	64,511	53,763	61,038	10,748	50,290
San Diego	220,259	103,137	84,208	136,051	18,929	117,122
San Francisco	73,339	46,951	45,724	27,615	1,227	26,388
San Joaquin	50,255	31,774	29,069	21,186	2,705	18,481
San Luis Obispo	13,794	6,750	5,148	8,646	1,602	7,044
San Mateo	52,844	17,698	14,765	38,079	2,933	35,146
Santa Barbara	33,483	15,127	12,458	21,025	2,669	18,356
Santa Clara	160,751	62,860	56,474	104,277	6,886	97,391
Santa Cruz	20,076	9,474	7,602	12,474	1,872	10,602
Shasta	12,977	7,192	5,942	7,035	1,250	5,785
Solano	27,830	12,304	9,263	18,567	3,041	15,526
Sonoma	33,145	17,198	14,539	18,606	2,659	15,947
Stanislaus	36,765	20,482	16,805	19,960	3,677	16,283
Sutter/Yuba	15,957	9,598	7,931	8,026	1,667	6,359
Tulare	42,305	28,015	24,587	17,718	3,428	14,290
Ventura	70,225	30,227	25,157	45,069	5,070	39,999
Yolo	13,419	6,690	5,516	7,903	1,174	6,729
Yuba	b	b	b	b	b	b
Contract County Programs, Total	36,304	19,337	15,888	20,416	3,449	16,967
Alpine	93	63	48	45	15	30
Amador	1,500	617	433	1,067	184	883
Calaveras	2,006	1,176	1,058	948	118	830
Glenn	2,767	1,390	1,074	1,693	316	1,377
Lake	3,426	2,349	2,138	1,288	211	1,077
Lassen	2,252	1,064	881	1,371	183	1,188
Mariposa	836	408	287	549	121	428
Modoc	1,091	653	565	526	88	438
Mono	712	267	191	521	76	445
Nevada	3,886	1,889	1,509	2,377	380	1,997
San Benito	3,626	2,063	1,715	1,911	348	1,563
Sierra	316	126	76	240	50	190
Siskiyou	4,675	2,386	1,944	2,731	442	2,289
Tehama	4,399	2,569	2,142	2,257	427	1,830
Trinity	1,376	673	488	888	185	703
Tuolumne	3,343	1,644	1,339	2,004	305	1,699

FOOTNOTES TO TABLE 2

1. The eligible population includes all Medi-Cal persons under 21 years of age and all non-Medi-Cal children between birth and age seven.

2. The target population includes all Medi-Cal persons under 21 years of age and non-Medi-Cal persons eligible for State reimbursed screens. (i.e., children aged 4-6 in families with incomes below 200 percent of AFDC levels plus non-Medi-Cal children in Head Start and State preschools).

3. Estimated number of Medi-Cal eligible persons under the age of 21.

4. Estimate of persons not eligible for Medi-Cal between the ages of 0-6.

5. Estimate of persons aged 4-6 years who are members of families whose income is below 200 percent of the AFDC minimum standards for adequate care. Also includes Head Start and State preschool children who are not eligible for Medi-Cal.

6. The other category are those children ages 0-6 who are not eligible for State funded screens.

7. Excludes that part of the county's population served by the Berkeley City Health Department.

a. Combined with Humboldt County.

b. Combined with Sutter County.

rce: Medi-Cal eligibles are based on a projection of CID eligibles by age and sex, March, 1977.

California Department of Finance, "Total Population Estimates for California Counties, July 1, 1970-1987."

Bureau of the Census, "Detailed Characteristics, California, Section 2, Table 207."

California State Department of Health, Center for Health Statistics, December 29, 1977.

Table 3

Number of Medi-Cal Screens, Eligible Population, and Percent of Eligible Population Screened Child Health and Disability Prevention Program

Fiscal Year	Number of Medi-Cal Screens[1]	Number of Medi-Cal Eligibles[2]	Percent Eligibles Screened
1975-76	58,968	1,268,301	4.7
1976-77	129,000	1,302,471	9.9
1977-78	188,626	1,348,293	14.0
1978-79[a]	234,617	1,306,639	18.0
1979-80[a]	302,825	1,405,631	21.5

1. Confidential Screening/Billing Reports (PM 160s) with at least the health history and physical examination provided. Includes both complete (70%) and partial screens (30%). Not included are an unknown number of EPSDT screens billed through the Medi-Cal billing system.

2. All Medi-Cal persons under age 21.

a. Figures for fiscal year 1978-79 and 1979-80 are projections.

Source: California State Department of Health Services, Child Health and Disability Prevention Branch, May 1979.

Table 4

NUMBER OF INDIVIDUALS SCREENED, REFERRAL STATUS AND AMOUNTS OF PAYMENTS FOR SCREENING SERVICES FOR SELECTED STATES (MAY, 1978)

SELECTED STATES	NUMBER OF INDIVIDUALS SCREENED DURING MONTH	INDIVIDUALS SCREENED WITH NO REFERRABLE CONDITIONS	INDIVIDUALS SCREENED WITH REFERRABLE CONDITIONS			TOTAL PAYMENTS FOR SCREENING SERVICES
			TOTAL	REFERRED FOR DIAGNOSIS AND/OR TREATMENT	NOT REFERRED	
STATE TOTALS	170,821	65,339	84,848	75,523	6,662	33,372,385
ALABAMA	6,407	1,067	5,340	5,100	240	121,509
ALASKA	387	171	216	109	107	38,812
ARKANSAS	3,042	1,810	1,232	1,232	---	208,037
CALIFORNIA	11,992	2,347	9,645	9,239	406	419,258
COLORADO	2,477	1,462	1,015	1,015	---	52,466
CONNECTICUT	3,409	1,453	1,956	1,743	213	49,556
DELAWARE	300	248	52	52	—	8,071
DIST. OF COL.	525	280	245	199	46	15,094
GEORGIA	7,023	1,368	5,655	4,638	1,017	173,575
HAWAII	782	451	331	331	—	12,475
IDAHO	2,102	1,706	396	395	1	51,054
ILLINOIS	6,632	5,885	747	747	—	85,628
INDIANA	6,580	—	—	—	—	284,782
IOWA	2,008	1,607	401	401	—	31,477
KANSAS	1,164	738	426	418	8	27,997
KENTUCKY	2,436	789	1,647	1,647	---	29,292
LOUISIANA	7,314	3,049	4,265	4,019	246	232,550
MAINE	382	341	41	41	—	11,460
MARYLAND	1,772	745	1,027	913	114	28,506
MASSACHUSETTS	12,599	—	—	—	—	—
MICHIGAN	10,343	5,683	4,560	4,555	5	—
MINNESOTA	930	393	407	173	234	22,793
MISSISSIPPI	6,237	450	5,787	5,787	—	118,322
MISSOURI	3,088	1,923	1,165	495	670	91,450
MONTANA	245	104	141	95	46	7,455
NEBRASKA	814	590	224	168	56	17,906
NEVADA	382	48	334	334	—	11,022
NEW HAMPSHIRE	486	346	140	140	—	8,454
NEW JERSEY	3,735	2,514	1,221	1,221	—	83,111
NEW MEXICO	773	438	335	335	—	21,097
NORTH CAROLINA	5,836	3,089	2,747	2,723	24	123,017
NORTH DAKOTA	257	23	234	226	8	14,095
OHIO	4,539	1,816	2,723	—	---	150,351
OKLAHOMA	1,105	636	469	194	275	18,098
OREGON	3,279	835	2,444	818	1,626	72,211
PENNSYLVANIA	17,643	6,436	11,207	11,207	---	—
PUERTO RICO	1,426	389	1,037	604	433	—
RHODE ISLAND	1,282	211	194	194	—	13,200
SOUTH CAROLINA	2,540	589	1,951	1,776	175	75,934
SOUTH DAKOTA	340	315	25	25	—	7,521
TENNESSEE	5,978	1,687	4,291	4,145	146	112,380
TEXAS	9,219	5,306	3,913	3,913	—	344,013
UTAH	621	517	104	88	16	11,895
VERMONT	624	613	11	11	—	15,729
VIRGINIA	2,667	1,822	845	639	206	44,147
VIRGIN ISLANDS	148	43	105	105	—	2,400
WASHINGTON	3,549	1,892	1,657	1,574	83	75,018
WEST VIRGINIA	1,813	876	937	937	---	27,338
WISCONSIN	1,339	621	718	557	161	46,717
WYOMING	82	47	35	15	20	1,230

Source: Health Care Financing Administration, Medicaid Statistics. May 1978. DHEW Publication No. (HCFA)78-03150, January 1979, Table 15, p. 24.

one in which the child received the specific screening procedures appropriate to his/her age and sex as defined in state regulations. A partial screen is a screen in which one or more of the required screening procedures were omitted by the screening provider.

There are certain instances in which a screening procedure may be omitted and yet the screen can be counted as a "complete" screen, for example, when a required screening procedure is refused by the parent, or when the provider deems the procedure inappropriate, unnecessary, or medically contraindicated. The current CHDP billing form (PM 160) has a column marked "refused" for each of the screening procedures. In the event this column is checked by the screening provider, a complete screen can still be credited. The current form does not, however, contain a column to indicate those screening procedures that were omitted because they were unneeded (according to the CHDP screening periodicity table), medically contraindicated, or deemed inappropriate by the screening provider. The only choice the screening provider has is to check a column labeled "not given". PM 160s with screening procedures maked "not given" cannot be counted as complete screens and thus cannot be included in federal reporting statistics.

The newly revised PM 160 has corrected this problem by including a new column labeled "refused, contraindicated, not needed" for each screening procedure. When screening providers check this column, the screens can be counted as complete screens and included in the federal reports. This change in the PM 160 will help to significantly increase the number of completed screens reported to HEW.

A related problem concerning partial screens is when a child receives part of the complete screen during one visit and the remaining part during a subsequent visit. Currently, these two partial screens cannot be linked to form a complete screen. The new PM 160 was designed to facilitate the linkage of partial screens to form complete screens. Two new items have been added to the PM 160 (i.e., a "partial screen" box and "accompanies prior PM 160 dated..."). Once the billing and information system is fully automated, linkages of partial screens will be possible using these new data items.

Another problem affecting reportable EPSDT screens concerns the so-called "dual billing" system. This issue is commented on in a subsequent response to a recommendation in Part II.

Response to Specific Recommendations

Page 10

Recommendation

The State's short-range plan should make the current reporting and billing system as accurate as possible.

Response

The CHDP Branch and the Data Systems Branch have been working together for the past two months to prepare for the implementation of the new PM 160 on May 1, 1979. Arrangements have been made by the Data Systems Branch to key-enter all of the data from the new PM 160, to edit these data, and to produce the local case management report (see Report C-1 in Attachment I).

The edited tape of "clean" PM 160 data will be given to the Center for Health Statistics who in turn will prepare the federal monthly EPSDT report (SRS-NCSS-120, part III). This tape will also be provided to the new Medi-Cal fiscal intermediary, CSC. CSC will be able to use this tape to check for duplicate billing and to produce the contracted reports which link screening services with diagnosis and treatment services. The monthly edited tape needed by Center for Health Statistics and CSC will begin being produced by July 1, 1979, in ample time to make any modifications to work out any bugs prior to November 1979, the date by which CSC must start receiving the tapes in order to meet their contractual requirements.

The CHDP Branch and Data Systems Branch have been meeting weekly and will continue to meet to discuss plans for the eventual automation of the PM 160 claims processing system. Meetings have also been held with DHS Accounting Section. The plans for automating the claims processing system will include an automated remittance advice and perhaps a checkwrite feature. The remittance advice is a form attached to each provider's check which summarizes the claims and amounts covered by that check.

Although the plans for automating the claims processing system and resolving the interrelationships among the Child Health Information and Claiming (CHIC) Unit, Accounting, and the Controller's Office will probably be completed by July 1, 1979, the actual implemnetation of the automated system is dependent on securing additional programmers, systems analysts, and timely keypunching turnaround. Until these necessary support resources can be obtained, the CHIC Unit will continue to manually process the PM 160s.

Recommendation

The State should develop a procedure to count equivalent, comprehensive physicals as complete screens.

Response

The Department has extensively researched this issue, which is sometimes referred to as the dual billing issue. HEW, Region IX, staff have identified this issue as a major problem, have participated in discussions dealing with this issue, and have been given the Department's working papers on this matter. Recommendations have been made and the Department is now evaluating these recommendations.

Recommendation

The State should replace the requirement for dual provider agreements (i.e., one for Medi-Cal and one for CHDP) with a requirement that providers must agree to participate in the CHDP Program as a condition of participation in Medi-Cal.

Response

HEW's recommendation that the State replace two agreements with one is very compatible with the Director's recommendation that spelling out conditions of participation should exist between the State and Medi-Cal providers, and CHDP is pursuing the resolution of this issue in that context.

Page 11

Recommendation

The State should plan to assume responsibility for or find alternatives for support services and overhead costs which are currently paid for by county governments.

Response

State CHDP regional staff are working closely with county staff to assist them in identifying costs for support services and overhead expended on CHDP activities that are now paid for with county funds. County funds identified will be used to draw down federal Title XIX monies.

The plan to claim for public health nursing time, developed with the assistance of Region IX HEW EPSDT staff, is one example.

Page 12

Recommendation

The State should ensure that the personnel budgets of the local CHDP programs only reflect the percentage of time they devote to it.

Response

At the time of the compliance review, EPSDT was not paying 100 percent of the salaries of the CHDP Deputy Directors in El Dorado and San Bernardino Counties, and Region IX staff were so informed.

San Bernardino's CHDP budget had not yet been approved, because of the incorrect time which had been budgeted for the Deputy Director. The budget has since been approved; the Deputy Director's time is budgeted at 80 percent and the duties were revised.

The El Dorado County Deputy Director was funded at 60 percent for Fiscal Year 1977-78 and at 65 percent for Fiscal Year 1978-79 for CHDP functions. The EPSDT functions in this county are the responsibility of the health educator, who was budgeted at 30 percent in Fiscal Year 1977-78 and at 42 percent in Fiscal Year 1978-79.

The State makes every attempt to ensure that local CHDP program budgets reflect only the percentage of personnel time devoted to CHDP -- and to the EPSDT component therein. State staff will continue to monitor local program staff activity and request budget revisions or reassignment of non-CHDP functions to other local staff.

Recommendation

That the State ensure that Medi-Cal cards and stickers be issued on a more timely basis.

Response

State authorization for counties to immediately issue Medi-Cal cards to beneficiaries faced with urgent medical needs has existed since 1971. Counties have the choice of issuing the card or of requesting the Department to issue the card based on the beneficiary's need. Approximately 200,000 cards are issued by the counties each month.

Recognizing the workload burden placed on the counties, the cost involved, and the potential for error in county produced cards, the Department has designed and is now developing a new eligibility data system. One feature of the new MEDS will be on-line computer print terminals located in county offices. These terminals will be linked directly to a Department operated master eligibility file. With minimal on-line data input from the county, the system will accept a card issuance request, verify the beneficiary's current eligibility, and produce a card for the worker to hand to the beneficiary. It is anticipated that the entire transaction will take less than two minutes to complete. Present plans call for implementation of this system to begin in November 1979 and to be installed in all counties by March 1981.

Ongoing cases -- Continuing eligible beneficiaries receive their cards the first of every month through the Central Identification Division on a routine monthly basis.

If the beneficiary does not have a label at the time the CHDP service is requested of the provider, the provider may ask the county for one. We assume that the delay noted is at this point.

We would also note that a Medi-Cal card is issued for eligible newborns the
first of the month following delivery, when the welfare department is notified *
of the birth in a timely manner. To ensure coverage for the newborn child *
in the meantime, however, services for newborns may be billed on the mother's
card during the month of delivery and the month following delivery (Section *

50733 (c)). If the mother has not received the newborn's card by the beginning of the second month after delivery, the county welfare department may issue a temporary card if immediate medical care is needed.

Recommendation

Regional consultants and county staff should devote more time to basic program monitoring.

Response

State and local CHDP staff do not "lack concern with monitoring the provision and quality of care of the health screening". Other priorities in program implementation have limited the amount of time spent on this activity. Regional staff will assist local staff in evaluating the screening activity of private providers, and will review provider recruitment and training activities with local program staff to assure that providers are receiving appropriate and correct information about the program.

Page 13

Recommendation

The function of the regional consultants should be clarified with respect to provision of technical assistance and information exchange with the State and among counties.

Response

The roles and functions of the Field Support Services Section and the regional consultants, and protocols for site visits and case management reviews are being developed. (See Attachment III.) This draft has been developed with state staff input and has been reviewed by the CHDP Subcommittee of Personal Health Services Committee of the California Conference of Local Health Officers.

*

→ Available from CHDP Branch, DHS.

It has been very well received and should clarify field staff responsibilities and relationships with other CHDP Branch staff and with local program staff.

Recommendation

That the State should explore with HEW possible methods of reimbursing counties for services of their nutritionists.

Response

The State has explored with HEW regional staff the availability of federal matching funds for EPSDT functions which county nutritionists perform. EPSDT funds will pay for outreach and health education services. It was our impression from the discussions that health and nutrition counseling are excluded from these reimbursable services, because counseling is considered a direct patient care, rather than outreach and health education. However, the State will continue exploring the matter with HEW.

The State will continue to provide in-service training in nutritional assessment and pediatric nutrition to meet the needs of staff development for nutritional services in the local communities. State and local staff will work with providers to ensure that nutritional assessment is provided, that children with potential nutritional disturbances are identified at early stages, and that counseling is given to their parents. Nutrition educational materials will be made available to both public and private providers.

State staff will continue working with local programs to identify and expand referral services through state allocations and other funding.

Recommendation

That the State ensure that the new PM 160 is used for the documentation of immunizations.

Response

The State CHDP Program has developed a provider instruction manual for using the PM 160 and has held extensive provider workshops relative to the form and the instructions. One part of the instructions deals with properly documenting the immunization portion of the form. Please refer to Attachment IV for the specific instructions on documentation of immunizations.

Page 14

Recommendation

The State should review its policies and practices regarding transportation and should take corrective action to assure that transportation is available as required in 42 CFR 431.53.

Response

Please refer to state comments in Section "b", Administration and Management.

Recommendation

The State should make information available in a form the counties can use and should keep this in mind when the automated data tracking system is planned.

Response

The case management report to be used by local CHDP programs has been redesigned (see attached Report C-1 in Attachment I). This report will be prepared separately for each of Los Angeles's five health services regions.

The regions will be identified by a code entered by CHDP providers on the new PM 160 (see Attachment II).

Response to Recommendations With Regard to Specific Counties

LOS ANGELES COUNTY

Recommendation

Discussions should begin with the Director of the Los Angeles County Health Department regarding the feasibility of delegating authority for the local CHDP program from the regional office to the CHDP program. Written inter-regional agreements should be signed to clarify the relationship with the county CHDP program.

Response

This issue has been addressed with local program staff. State regional staff continue to encourage county regional input into plan development and into program planning. State staff meet with county regional staff periodically.

The suggestion of written agreements between regions and the central CHDP office is an excellent one and will be explored.

Recommendation

Immediate distribution of cases to the EPSDT Functional Units should be undertaken to begin the outreach process.

Response

The EPSDT Functional Units are receiving batched cases on a timely basis, namely once or twice a week, and the outreach process is occurring.

Recommendation

The terms of the Los Angeles County CHDP program's interagency agreement with Department of Public Social Services should be implemented immediately.

Response

The terms of the interagency agreement state that an audit of the case management system will be done. The County Auditor's Office will conduct an audit in the first quarter of Fiscal Year 1979-80 to determine if the case management system devised by the health and welfare department is functioning adequately.

SAN BERNARDINO COUNTY

Recommendation

Increased provider recruitment and provider education is called for.

Response

State CHDP regional consultants have developed a plan of action which will:

> Assist program staff to analyze present provider network to identify those areas where recruitment and/or education is needed.
>
> Assist program staff to develop a tool for evaluating private providers' screening activity and to identify needs for provider education.

Recommendation

The local program should continue reviewing cases for documentation and completeness.

Response

State regional staff will conduct quarterly reviews using samples of at least five PM 160s. Timeliness and completeness of screening procedures according to age and periodicity schedule will be documented. Program staff will be requested to commit themselves to the above activity in writing in the annual plan.

In addition, state and local staff will conduct quarterly reviews of the case management system using a previously developed tool. Gaps in the system will be identified and ways of avoiding them will be developed. Program staff will be requested to commit themselves to the above activity in writing in the annual plan.

SAN MATEO COUNTY

Recommendation

A provision for retraining should be included as part of the interagency agreement. Consideration could be given to rotating eligibility workers from Social Services into the EPSDT units. This would provide training and firsthand experience with the CHDP Program.

Response

Regional state staff will meet with the new CHDP Deputy Director and with welfare department staff to reevaluate training of eligibility workers. A committee of State CHDP and Social Service staff is developing a plan for eligibility worker training. Input from local welfare department staff will be sought in the development of this plan.

Recommendation

San Mateo County must reinforce provider education regarding the completeness of screens.

Response

State regional staff will again meet with the new Deputy Director to develop a plan for improvement of provider education activities so that the program screening requirements are more clearly understood and provided.

The state regional staff will assist local staff in identifying those providers most in need of further training.

ALAMEDA COUNTY

Recommendation

The local program must take immediate steps to monitor all PM 160s and the case management activities more closely. More staff, especially public health nurses, must be hired to carry out the monitoring function.

Response

Public health nurses have already been hired. Regional state staff have met and will continue to meet with local staff to assist them monitor PM 160s, and in developing their case management system.

EL DORADO COUNTY

Specific comments on El Dorado were omitted. This program is functioning very well and we suggest that the assessment report should acknowledge that fact.

PART IV
COUNTY RESPONSES

Each of the five counties that were reviewed were sent a copy of the assessment report. The State CHDP Branch requested that each CHDP Director and Welfare Director of the five reviewed counties review this report for its accuracy and interpretation, and submit comments for inclusion in the State's response if desired.

Counties submitting responses were:

Los Angeles County
CHDP Program

Los Angeles County
Department of Public Social Services

San Bernardino County
Department of Public Health

El Dorado County
Health Department

San Mateo County
Department of Public Health and Welfare

Alameda County
Health Care Services Agency

Responses from these counties follow.

COUNTY OF LOS ANGELES - DEPARTMENT OF HEALTH SERVICES
CHILD HEALTH AND DISABILITY PREVENTION PROGRAM
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May 1, 1979

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HEALTH SERVICES
PREVENTIVE/PUBLIC HEALTH
HOSPITALS
COMPREHENSIVE HEALTH CENTERS
COMPARATIVE VETERINARY MEDICINE

REGIONS

CENTRAL
110 North Mission Road
Los Angeles 90033
Phone 213-226-6734

COASTAL
1401 Chestnut Avenue
Long Beach 90813
Phone 213-533-2104

SAN FERNANDO-ANTELOPE VALLEY
7533 Van Nuys Boulevard
Room 400 - South Tower
Van Nuys 91405
Phone 213-997-1800

SAN GABRIEL VALLEY
1435 West Covina Parkway
West Covina 91790
Phone 213-933-7027

SOUTHEAST
20 Compton Avenue
Angeles 90059
Phone 213-603-5101

Dr. Siegried A. Centerwall
CHDP Branch
Department of Health Services
714 P Street, Room 300
Sacramento, California 95814

Dear Dr. Centerwall:

This letter constitutes our response to Section F of the Region IX Health Education Welfare (HEW) California State assessment of Early Periodic Screening Diagnostic Treatment (EPSDT) November 6-17, 1978. Except for a few brief corrections to various parts of the report, we shall limit ourselves to comments made about Los Angeles.

> On page 9, the number (124,688) should read, "---- represents less than 10 percent (not one percent) ---."
>
> On page 10, although prompt processing of P.M. 160's at the state level is essential, said processing is not necessary or even normally related to the initiation of local follow up for discovered conditions. Local programs receive their own copy of the PM 160.
>
> On page 12, it should be noted that a mother's Medi-Cal Card can be used for her new baby in the month of birth plus the succeeding one month.

Regarding comments specific to Los Angeles County (pp.15-16). This organizational pattern is in conformity with County policy. The role of headquarters staff, although not immediately supervisorial, is more than consultative. It does in fact direct the overall program goals.

For the sake of accuracy, it should be noted that the five Regions are just that--regions of a single Health Department. The Regional Child Health and Disability Prevention (CHDP) Coordinator does not report to the Director of Public Health (title Deputy Director Preventive/Public Health) but rather to the Regional Deputy Director. The CHDP Program Director (currently R. Weiss) reports to the Public Health Deputy. A meeting has recently been held among the Deputy Director for Public Health, the CHDP Director and the five Regional Coordinators. The respective responsibilities were reviewed and the necessity to be in compliance with the acceptable usage of State CHDP Program dollars was stressed.

The EPSDT Units are functioning in all five regions. All cases referred from the Department of Public Social Services (DPSS) (Welfare) are being case managed within the accepted time constraints.

CURING IS COSTLY... PREVENTION PRICELESS!

Dr. Siegried A. Centerwall
Second Page
May 1, 1979

As relates to monitoring, our departments, Department of Health Services (DHS) and DPSS, have agreed to a formal process of case monitoring. This will involve the on site participation by State CHDP Regional Consultants. There will be a record review within DHS alone, at least once a year, plus a tracking review of cases starting at DPSS and proceeding to DHS also at least once a year. This will commence in May 1979.

Finally, the Los Angeles County Auditor-Controller's Department has agreed to review our case management and systems procedures, including summary reporting documents between our departments, at least once a year. The first such review shall have taken place by September 30, 1979. The above is being included in our Interagency agreement, which I anticipate will be agreed to by the departments.

I have enclosed a copy of the State's summary of the Los Angeles Review (November 7-9, 1978) plus my response to Anthony Oreglia of November 15. You may use that response in part or toto as you see fit.

Sincerely,

Robert C. Weiss, M.D.
Director, CHDP Program

RW:jn
Enclosures
cc: Eileen Miggins
Ruben Gonzalez

KEITH COMRIE
DIRECTOR
ED TANAKA
ASSISTANT DIRECTOR

COUNTY OF LOS ANGELES
DEPARTMENT OF PUBLIC SOCIAL SERVICES
3401 RIO HONDO AVENUE EL MONTE CALIFORNIA 91731/TEL (213) 572-5720
P O BOX 5493 EL MONTE CALIFORNIA 91731

BUREAU DIRECTORS
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MARTIN E. WOODS

May 4, 1979

Dr. Siegried A. Centerwall, Chief
Child Health & Disability Prevention Branch
Department of Health Services
714 P Street, Room 300
Sacramento, California 95814

Dear Dr. Centerwall:

HEW REVIEW OF CHDP

We have reviewed the HEW draft report on California's Child Health, Disability, and Prevention (CHDP) program for accuracy and interpretation. From our perspective, the report is a fair statement and description of this program as it operates in Los Angeles County. In addition, we would like to offer the following comments to select portions of the report:

FINDING: PROPOSITION 13 REPERCUSSIONS (p. 11)

This finding recommends individual county analysis of CHDP support services which are currently paid by county governments, but which may be chargeable to the CHDP program. We are reviewing our current billing practices, particularly in regard to Quality Control administrative costs and transportation services expenses.

FINDING: DELAYS IN ISSUANCE OF MEDICAID ELIGIBILITY CARDS (p. 1

This section of the report recommends more timely State issuance of Medicaid eligibility cards and stickers to facilitate timely local provision of screening services. We support this recommendation and understand that the State has already begun action in this area.

FINDING: LACK OF BASIC PROGRAM MONITORING (p.12)
and
LACK OF INTEREST IN MONITORING (p. 15)

The Los Angeles County Departments of Public Social Services and Health Services recognize the need for basic program review and management information systems to adequately assess compliance with program requirements and monitor daily operations. The systems are now largely in effect within the county and, over the next several months, will be supplemented with independent management and systems reviews by the Los Angeles County Auditor Controller Department.

Further, a revised Interagency Agreement between the Departments of Public Social Services and Health Services is in the final stages of completion for FY 79/80. This agreement formalizes the new management and information and program monitoring systems.

FINDING: USE OF REGIONAL CONSULTANTS (p. 13)

We would like to compliment our Regional Consultant from the State Department of Social Services on her professionalism and truly helpful assistance. Her technical expertise and fulfillment of her liaison role have contributed greatly to the operation of the CHDP program in this county.

Thank you for the opportunity to comment on this report.

Very truly yours,

Jan Pollard, Chief
Management Information and
Evaluation Division

JP:RJC:hmc

cc: Keith Comrie
Eddy Tanaka
Bureau Directors
Dr. Robert Weiss (Health Services)
Sylvia Novak (SDSS)

DEPARTMENT OF
PUBLIC SOCIAL SERVICES

County of San Bernardin
HUMAN RESOURCES AGENC

FRED F. THIES, Director
Department of Public Social Serv

Reply to:
XX 670 East Gilbert Street
San Bernardino, CA 92404
17830 Arrow Blvd.
Fontana, CA 92335
515 Orange Street
Redlands, CA 92373
325 East "C" Street
Ontario, CA 91764
200 East Buena Vista Avenu
Barstow, CA 92311
15347 Sixth Street
Victorville, CA 92392
56316 Twentynine Palms Hw
Yucca Valley, CA 92284

April 30, 1979

CHDP BRANCH
MAY 7 1979
STATE DEPT. OF HEALTH

Siegried Centerwall, M.D., Chief
Department of Health
Child Health and Disability
Prevention Branch
714 "P" Street, Room 300
Sacramento, California 95814

Dear Dr. Centerwall:

In response to your request for comments regarding the DHEW review of California's CHDP Program, San Bernardino County submits the following:

Page 6, Informing: Not all applicants responding "yes" to Question 22 are subsequently given names of CHDP providers. In San Bernardino County, these clients are instructed as to the various methods of service delivery (Health Department, other providers, etc.) at intake. During the intensive informing phase, via the Health Department's EPSDT unit, specific health care providers are selected. This section should be amended to show the variations between counties.

Page 14, Conflicting Regulations Regarding Transportation: In our county, service referrals are responded to regardless of program. However, recent Title XX reduction in funds jeopardizes the ability to comply with this requirement.

DHEW's recommendation to "assure that transportation is available" will only occur if funding levels are adequate to meet this need.

San Bernardino County has begun corrective action in those areas cited in the Draft. Funding of the Deputy Director's salary has been modified to reflect the joint Administrative responsibilities and, in addition, efforts have begun both to increase the number of certified providers and to improve documentation practices.

Thank you for the opportunity to comment.

Sincerely,

Fred F. Thies

FRED F. THIES, DIRECTOR
DEPARTMENT OF PUBLIC SOCIAL SERVICES

LOUIS E. MAHONEY, M.D., Director
DEPARTMENT OF PUBLIC HEALTH

FFT:LEM:FAS:smr

EL DORADO COUNTY
HEALTH DEPARTMENT

931 SPRING STREET
PLACERVILLE, CALIFORNIA
95667
PHONE (916) 626-2255

P.O. BOX 14506 — BRANCH OFFICE
SOUTH LAKE TAHOE
CALIFORNIA 95702
PHONE (916) 541-7262

May 9, 1979

Siegried Centerwall, M.D., Chief
Dept. of Health Services
Child Health and Disability Prevention Branch
714 P Street, Room 300
Sacramento, CA 95814

Dear Dr. Centerwall,

The El Dorado County Health Department has reviewed the draft report of the Department of Health, Education and Welfare (DHEW) assessment of California's Child Health and Disability Prevention Program and wish to make the following comments:

1. Considerable time and effort was expended by County Health Department personnel with this assessment process and there are no comments favorable or unfavorable relative to our program. Staff would feel more comfortable if some reference was made relative to their program.

2. On page twelve (12) of the report, it states that EPSDT is paying for 100% of the Deputy Director's time in El Dorado and San Bernadino counties even though some time is devoted to administration of other programs. This is a gross misstatement of fact relative to El Dorado County. None of the Deputy Director's time is charged to the EPSDT budget.

Hopefully, this brief summarization would enable your office to respond to DHEW's draft report. Additionally, the County would appreciate input from your office relative to your comments.

Sincerely,

Edward Q Redmond

Edward Q. Redmond
Director of Administrative Services

C.HDP BRANCH
[illegible]

EQR;jk

Department of Public Health and Welfare
Public Health Division

BOARD OF SUPERVISORS
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COUNTY OF SAN MATEO
225 WEST 37TH AVENUE · SAN MATEO · CALIFORNIA 94403

May 11, 1979

CHDP BRANCH
[illegible]
STATE DEPT. OF HEALTH

Siegried A. Centerwall, M.D., Chief
Department of Health Services
CHDP Branch
714 P Street, Room 300
Sacramento, CA 95814

Dear Dr. Centerwall:

The draft report of the Department of Health, Education and Welfare's assessment of the California Child Health and Disability Prevention Program has been reviewed by San Mateo County.

The program concurs with the finding that detailed the inadequate training of Social Service eligibility workers and has made arrangements to correct this situation. A recent agreement between the Division of Social Services and the Division of Public Health assures that the CHDP Program will retrain Social Service eligibility workers on an annual basis, in addition to the initial training session that is part of the workers' orientation to the AFDC Program.

During the establishment of a provider network, the program emphasized provider participation and not necessarily provider comprehension of the scope and purpose of the CHDP Program.

The need to expand the provider's knowledge base was formally addressed during the recent training sessions which were necessitated by the revision of the screening and billing report form (PM 160).

The program does not share the review team's opinion that several cases represented incomplete screens. This may be due to misinterpretation and misapplication of the periodicity table. The team considered screens incomplete if an age appropriate test was not given, even if the periodicity table allowed the provider a choice of ages for administering a test, i.e., the 4 year old that did not receive a vision screening, even though the table recommends the test at age 4 or 5 years. Furthermore, no allowance was made for individual medical judgment even when the physician noted his reasons for eliminating a particular component of the health assessment. Many of these problems have been eliminated with the adoption of the new regulations and frequency schedule.

Thank you for providing us with the opportunity to submit our comments on the Department of Health, Education and Welfare's report.

Sincerely,

James M. Bodie, M.D., M.P.H.
Public Health Director

JMB:bkd

cc: Regional Consultant Staff, CHDP
Department of Health
2151 Berkeley Way
Berkeley, CA 94704

ALAMEDA COUNTY
HEALTH CARE SERVICES
AGENCY

CHILD HEALTH AND DISABILITY PREVENTION PROGRAM

AGENCY HEADQUARTERS
499 Fifth Street
Oakland, California 94607
Telephone number (415) 874-7292

May 9, 1979

Siegried A. Centerwall, M.D. Chief
Department of Health Services
Child Health and Disability Prevention Branch
714 "P" Street, Room 300
Sacramento, CA 95014

Dear Dr. Centerwall:

We have reviewed the draft report of the Department of Health, Education and Welfare (DHEW) assessment of California's Child Health and Disability Program; our comments are as follows:

1. The split between CHDP provider/billing and Medi-Cal provider/billing is State responsibility not County. The result of this split is that countys (including Alameda) waste thousands of dollars in staff time trying to convince or pursuade providers to use the PM 160 to bill CHDP instead of the Medi-Cal. This is a continuing, never ending process. For example, Children's Hospital required 3 meetings of about two hours each to convince them to participate in the first place. Once they agreed to participate, it was necessary to meet with them frequently (every two or three weeks) to reconvince them of the worthwhileness of the program. Presently, they are costing out the manual billing system to determine if they can afford the manual billing system. If not, they will withdraw depriving the program of 350 PM 160's per month or 4,200 annually.

   Other providers will only use the CHDP program as a resource of last resort, i.e., billing for State funded 200 percenters. An example of this is La Clinica De La Raza who uses Medi-Cal extensively.

2. It is the State's responsibility not the County's responsibility to assure that the CHDP providers are reimbursed in a timely manor. Thousands of dollars of county CHDP staff time is wasted in pacifying providers when payment is delayed.

   Our recommendation is that the State automate the CHDP/CHIC unit procedures as recommended on page 15 of the report.

3. Alameda County has assigned a Senior PHN to the CHDP program as of May 14, 1979. The filling of this position was delayed by the hiring freeze imposed as the result of Proposition 13. Presently, the program has two half-time PHN's and one full-time Senior PHN whose duties include monitoring all PM 160s. Additionally, the county has assigned eight full-time equivalent public health nurses to EPSDT services as of April 1, 1979.

We appreciate the opportunity to review this report.

Very truly yours,

Librado Perez

Librado Perez, Director
Alameda County Social Services Agency

Stewart Gross, M.D., Director
Alameda County Health Care Services Agency

MCR:lm

ATTACHMENTS

```
(MONTH)    (YEAR)                     CALIFORNIA DEPARTMENT OF HEALTH SERVICES
XXXXXXXXX  XX                    CHILD HEALTH AND DISABILITY PREVENTION PROGRAM

(COMMUNITY PROGRAM)*                              REPORT C-1
XXXXXXXXXXXXXXXX                   ALL INDIVIDUALS SCREENED,REFERRED,TREATED

1  2          3                      4            5     6  7       8            9       10 11  12 13  14    15        16

S  EM       PATIENT NAME          MEDI-CAL      BIRTH   S PHIGD  PROVIDER    SCREEN   P R   OP SUSP     RX       CHDP
                                  NUMBER        DATE    E NUMBER  NUMBER      DATE    S C      PROB    DATE    CONTROL
                                                        X                                 H    AP FC           NUMBER

X  XX XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXX XXXXXX X XXXXX XXXXXXXXXXX XXXXXX X XX XX XX X XXXXXX XXXXXXXXXXXXX
   .          .                   .             .     .  .        .           .    . .  .  .  .   .        .
   .          .                   .             .     .  .        .           .    . .  .  .  .   .        .
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   XX XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXX XXXXXX X XXXXX XXXXXXXXXXX XXXXXX X XX XX XX X XXXXXX XXXXXXXXXXXXX
   (2)        (25)                (14)          (6)   (1) (5)    (11)        (6)  (1)(1)(2)(2)(1) (6)       (13)
```

*separate C-1 report is to be prepared for each of the five regions within Los Angeles County.

Glossary:

"Individuals": All persons regardless of funding source for whom PM 160's or EPSDT related Medi-Cal claims were processed for month of report or for prior months as indicated by entry month (see below) criteria. Individuals are to be listed on Community Program report according to county of residence (2 digit code) on PM 160

1. FS = Funding Source:
    11 = Medi-Cal Claim (Patient eligibility box numbered 1 marked, 14 digit Medi-Cal ID number entered).
    12 = Medi-Cal claim on Headstart/State Preschool preprinted PM 160 with 5 digit Headstart number in 15 digit box, bottom right corner.
    13 = Medi-Cal on HS/SPS preprinted PM 160 with 15 digit SPS number in 15 digit box.
    21 = Patient eligibility box numbered 2 marked.
    22 = Non-Medi-Cal claim on HS/SPS preprinted PM 160 with 5 digit HS number in 15 digit box.
    23 = Non-Medi-Cal claim on HS/SPS PP PM 160 with 15 digit SPS number in 15 digit box.
    31 = Patient eligibility box numbered 3 marked.

2. EM = Entry month: Calendar Mo.(01-12) in which individual's name first appears.
    Patient received complete screen, no OP, no AP - carries for EM only.
    Any other entry - carries for EM only.

3. Patient name: Last, first, middle initial as appears on PM 160.

4. Medi-Cal number: 14 digit Medi-Cal number as appears on PM 160. Underline 3rd and 4th digits (aid code).

5. Birthdate: 6 digit number as appears on PM 160.

6. Sex: Number 1 or 2 as appears on PM 160

7. PM 160 number: Number entered in 5 digit box, bottom right hand corner.

8. Provider number: 11 digit provider of service number on PM 160.

9. Screen date: 6 digit number as appears on PM 160 (Date of Service).

10. PS: P = Primary PM 160 - No mark in "Partial Screen" and "Screening Procedure Recheck" boxes.
    S = Secondary PM 160 - Mark in "Partial Screen" and/or "Screening Procedure Recheck" boxes

11. RCN: Two digit assessment procedure code with outcome column 2 (Refused, Contraindicated, Not Needed) marked. for those assessment procedures appropriate to recipient's age and sex as required by CHDP regulations. List one under another if more than one.

12. OP - Two digit assessment procedure code with outcome column 3 (Omitted) marked. List one under another if more than one.

Suspected Problem

13. AP = 2 digit assessment procedure code with outcome columns 4 (Problem Suspected, New) and/or 5 (Problem Suspected, Known) marked.

14. FC 1 - Digit follow up code entered in outcome columns 4 or 5 opposite appropriate 2 digit AP number.

15. RX date = 6 digit number appearing as date of Medi-Cal service on EPSDT related Medi-Cal bill.

16. CHIC control number = 13 digit number on top right hand corner of PM 160.

Monthly number of unduplicated recipient totals by funding source as follows:

Unduplicated individuals, total:
Unduplicated individuals, total 11:
Unduplicated individuals, total 12:
Unduplicated individuals, total 13
Unduplicated individuals, total 21
Unduplicated individuals, total 22
Unduplicated individuals, total 23
Unduplicated individuals, total 31

Key

FS - Funding Source
    11 - Medi-Cal
    12 - Medi-Cal Headstart
    13 - Medi-Cal State Preschool
    21 - State Reimbursed
    22 - State Reimbursed Headstart
    23 - State Reimbursed State Preschool
    31 - Information Only

EM - Entry Month
OP - Omitted procedure code; Suspected Problem
AP - Assessment Procedure Code
FC - Follow Up Code

DEPARTMENT OF HEALTH SERVICES

COUNTY OF LOS ANGELES
CHILD HEALTH AND DISABILITY PREVENTION PROGRAM

SCREENING POLICY

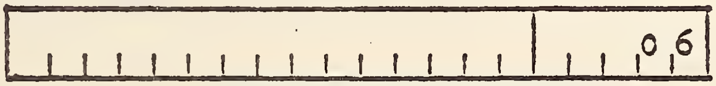
SUBJECT: REGIONAL CODING OF PATIENT'S RESIDENCE

POLICY

These codes are to be used in the extreme lower right corner of the PM 160 (rev. 7/78) as follows:

01 - Countywide, used where the region of patient's residence is unknown, or when the patient resides in another county.
02 - Central region
03 - Coastal region
04 - San Fernando region
05 - San Gabriel region
06 - Southeast region
99 - Assigned at state level for errors, i.e.: a blank space or error in coding -- 08 etc.

Boxes located at bottom of PM 160



i.e., Southeast Region

EFFECTIVE DATE: May 1, 1979

APPROVED: ______________________

Robert C. Weiss, M.D.
Director

"Individuals": All persons regardless of funding source for whom PM 160's or EPSDT related Medi-Cal claims were processed for month of report or for prior months as indicated by entry month (see below) criteria. Individuals are to be listed on Community Program report according to county of residence (2 digit code) on PM 160

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12. OP - Two digit assessment procedure code with outcome column 3 (Omitted) marked. List one under another if more than one.

Suspected Problem

13. AP = 2 digit assessment procedure code with outcome columns 4 (Problem Suspected, New) and/or 5 (Problem Suspected, Known) marked.

14. FC 1 - Digit follow up code entered in outcome columns 4 or 5 opposite appropriate 2 digit AP number.

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16. CHIC control number = 13 digit number on top right hand corner of PM 160.

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Unduplicated individuals, total:
Unduplicated individuals, total 11:
Unduplicated individuals, total 12:
Unduplicated individuals, total 13
Unduplicated individuals, total 21
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Unduplicated individuals, total 31

Key

FS - Funding Source
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   22 - State Reimbursed Headstart
   23 - State Reimbursed State Preschool
   31 - Information Only

EM - Entry Month
OP - Omitted procedure code; Suspected Problem
AP - Assessment Procedure Code

INTRODUCTION

This material has been developed to delineate the roles, responsibilities, and relationships of the Field Operations Section, CHDP Branch, State Department of Health Services, and the Family and Children Social Services Operations Branch, State Department of Social Services. Concomitantly, it describes relationships between the Regional Consultants of the above departments and local CHDP program staff.

It is intended that the material contained herein be reviewed periodically and revised as needed to meet changing program needs at both the State and Local level.

NOTE: THE 30 PAGES OF ATTACHMENT III HAVE BEEN REMOVED BY HEW, WITH THE CONCURRENCE OF DHS, DUE TO ITS BULK. HOWEVER THE ENTIRE ATTACHMENT IS AVAILABLE FROM THE CHDP BRANCH UPON REQUEST.

IMMUNIZATIONS: Mark one of the columns headed 1–5 for each immunization listed. When MMR, MuR, or MR are given, do not mark corresponding single entry codes.

IMMUNIZATIONS	GIVEN TODAY		NOT GIVEN TODAY		
	NOW UP TO DATE FOR AGE 1	STILL NOT UP TO DATE FOR AGE 2	ALREADY UP TO DATE FOR AGE 3	REFUSED OR CONTRA-INDICATED 4	OMITTED 5
31 POLIO—ORAL			✓		
32 DPT/Td			✓		
33 MMR ☑ 1 MuR ☐ 2 MR ☐ 3	✓				
34 MEASLES					
35 MUMPS					
36 RUBELLA					

33 MMR ☐ 1 MuR ☑ 2 MR ☐ 3	✓				
34 MEASLES			✓		
35 MUMPS					
36 RUBELLA					

33 MMR ☐ 1 MuR ☐ 2 MR ☑ 3	✓				
34 MEASLES					
35 MUMPS			✓		
36 RUBELLA					

First determine if an immunization is to be GIVEN TODAY or NOT GIVEN TODAY.

If GIVEN TODAY:

Now up to Date for Age: The immunization given today brings the patient up to date for age.

Still not up to Date for Age: The immunization given today does not bring the patient up to date for age.

If NOT GIVEN TODAY:

Already up to Date for Age: Immunization status is already current or the patient has had the disease.

Refused or Contraindicated: Patient or responsible person refuses needed immunization; the administration of a needed dose is medically contraindicated or deemed inappropriate.

Omitted: A needed dose was not administered for any reason not covered by "Refused or Contraindicated".

Provide the parent or patient with the California Immunization Record (yellow card) as the patient's permanent record of immunizations.

Section G
Utilization Control

I. The State's Waivered Utilization Review System

Acute Hospitals

A. Recommendation (Written Criteria) (Page 5)

Written criteria should be utilized by Medi-Cal consultants during the period in which the State's present utilization review system continues to be in effect. Medi-Cal consultants should document in their decisions and deferrals how criteria were or were not met and communicate this to the physician requesting the admission.

Response (Written Criteria)

As mentioned earlier, 22 medical criteria sets have been drafted including the most common or controversial surgical admissions, plus a criteria set on terminal care, and a set of criteria covering hospital admissions for mental illness.

These drafts have been reviewed by the medical consultants in the field offices, by certain provider organizations, and by the County Mental Health Directors Conference.

These guidelines are now being finalized and will be established by regulation. Consultants will use these criteria as a basis for their review of treatment requests.

B. Recommendation (Length-of-Stay Standards) (Page 5)

The length-of-stay standards being used by the Medi-Cal consultants and those in the code should be brought into agreement.

Response (Length-of-Stay Standards)

The medical criteria sets described above will incorporate length of stay standards prepared by the California Health Data Corporation. The standards currently incorporated in Title 22, California Administrative Code, Section 51327, represent the usual maximum permitted under the Medi-Cal program. A Medi-Cal physician consultant may authorize fewer than the days established by regulation if community practice recognizes stays of lesser duration. The standards as adopted will provide for some flexibility to satisfy the different standards applied in various communities.

C. Recommendation (Quarterly Monitoring) (Page 6)

The State should begin regular quarterly field office reviews and should adhere to the schedule attached to the memorandum dated September 18, 1978. Following completion of this schedule, the State should continue regular quarterly reviews.

Response (Quarterly Monitoring)

This recommendation was responded to in the Administration and Management section but is repeated here. Review of field offices was initiated in September of 1978. Nine (9) of twelve (12) field offices were reviewed prior to December 1, 1978. At that time, assignments relating to the new fiscal intermediary temporarily interrupted visits to the remaining three offices. Chronic physician staff shortage will be relieved with the expected hiring of three additional physicians between July 1, 1979 and September 1979. It is anticipated that field reviews will resume in the fall of 1979.

D. Recommendation

Medical Care Evaluation (MCE) studies which include Medi-Cal patients must be required by the State and must be conducted in acute hospitals during the period in which this system continues to be in effect.

Response

We agree. All institutional providers will shortly receive a Medi-Cal bulletin which will remind them of this requirement.

E. Recommendation

Either through training and/or written communication, Medi-Cal consultants should be informed of the prolonged care criteria and the need for their application. The application of the criteria should be clearly documented when these determinations are made.

Response

A memo has been sent to field administrators and consultants reiterating the need to follow prolonged care criteria (including documentation) and locating responsibility with Medi-Cal field administrators. Statewide training for administrators and consultants has been scheduled.

Although not always documented, the prolonged care criteria have been followed by the field offices, as evidenced by a field evaluation (Attachment A), conducted in 1976, which showed that in only 1 case of 79 reviewed was placement inappropriate.

F. Recommendation

Title XVIII-XIX skilled nursing facilities (SNFs) should be informed clearly that MCEs which include Medi-Cal patients must be performed as a requirement of the Medi-Cal program. Instructions which will improve the quality of the studies currently being performed would also be helpful.

The MCE process described in the August 13, 1978 memorandum to Title XIX SNFs should be monitored closely to assure that the MCE requirements are met.

Response

The State has agreed to notify all institutional providers via the Medi-Cal bulletin that Title XIX patients must be a part of MCE studies. In those facilities that are Title XIX only, this will entail the fulfillment of the requirement for participation. In Title XVIII and XIX facilities, Licensing and Certification has been asked to check if Medi-Cal patients are included when they approve the plans.

The State Medical Review Teams will check to assure this is done as a part of the annual review of patients in SNFs and mental hospitals.

G. Recommendation

DHS should notify all Title XIX providers that MCE studies are a requirement and a condition of participation (42 CFR 450.19 (x)).

Response

All institutional providers will shortly receive a Medi-Cal bulletin which will remind them of this requirement. Licensing and Certification is also notifying SNF and mental hospitals of this requirement via their health facility field staff as well as the letter that went out in August 1978.

H. Recommendation

Written criteria (42 CFR 450.18 (5) (c)) must be utilized by Medi-Cal consultants during the period in which the State's present utilization review system continues to be in effect. Moreover, such criteria should be uniformly applied to all facilities classified as Institutions for Mental Diseases -- private or state operated.

Response

See response to first recommendation in this section.

HEW State Assessment -- Program Subsystems

I. Recommendation

1. DHS should submit to HEW the Fresno/Madera project and a description of the utilization review system under the Redwood project for approval.

   Response

   The current Redwood project contract was submitted to HEW and was originally approved on October 24, 1977. The contract was subsequently modified and resubmitted to HEW on March 31, 1978. Final contract approval from HEW was dated April 11, 1978. If there is any problem relative to that approval, it is internal to HEW. The Department is already drafting a new contract to be negotiated and effective September 1, 1979. This contract will have additional language from the current one and will also be submitted to HEW for approval. We would assume that this approval constitutes approval in full of all federal requirements.

2. The State should make a decision as to which system is the superior one.

   Response

   The Department assumes that the reference to alternatives relates to the Fresno/Madera project on one hand and the ongoing prior authorization system on the other. The Department has just completed an evaluation of the project for services through December 1977 and administrative costs through June 1978. The findings were that the project was reasonably successful in controlling factors subject to peer review, namely, the cost per unit of service and the number of services per user. There is a question as to whether the approach is applicable on a statewide basis, however.

   We are, therefore, proposing to extend the existing subcontract with the Fresno/Madera Foundation through our contract with Medi-Cal Intermediary Operations (MIO) while we negotiate a direct contract between the Department and Fresno/Madera setting forth terms and conditions that we feel would be appropriate. In addition, should any federal waiver to the statewide utilization review system be necessary, it would become part of the federal approval process for this new contract.

As a final comment, Fresno/Madera does not include services other than those that were physician initiated so that services such as dental, chiropractic, podiatric, etc., were not covered by the project. Dental services were initially covered, but were deleted some time ago. Also, prior authorization was required for non-Formulary drugs and for durable medical equipment for Medi-Cal beneficiaries not resident to the two counties.

J. Recommendation

Department of Health should make every effort to ensure that all state operated mental hospitals are properly certified for the levels of care for which recipients are receiving services. This is especially critical in the ICF/DD (ICF/MR) area. The levels of care for which state institutions are certified have major implications for staffing, proper care, and space requirements for ICF/DD (ICF/MR) recipients. Attachment 2 represents the situation that exists at Stockton State Hospital in regards to ICF/DD. The single state agency must also ensure that there is a qualified mental retardation professional on the independent professional review (IPR) team for the ICF/DD Medi-Cal recipients' annual review. References: 42 CFR 442.411-442.431 -- staffing; 42 CFR 442.477 -- space requirements; 42 CFR 456.602 -- inspection teams.

Response

The ICF/DD regulations became effective April 1, 1979. As of then, nine state hospitals have certified the following numbers of ICF/DD beds:

Camarillo State Hospital ---------- 660
Patton State Hospital ------------- 538
Napa State Hospital --------------- 498
Agnews State Hospital ----------- 1,519
Porterville State Hospital ------ 1,354
Fairview State Hospital ----------- 650
Lanterman State Hospital -------- 1,428
Sonoma State Hospital ----------- 1,180

The Field Services Section is aware of the need for a qualified mental retardation professional as the IPR team, and this topic was addressed specifically at the recent training session (attended by HEW Region IX staff). The Field Services Section is currently exploring various options for ongoing procedures to ensure that this requirement is met.

K. Recommendation

Personnel in Medi-Cal funded positions in state institutions must perform Medi-Cal related functions. They should report to other senior level state staff, e.g., Medi-Cal field office administrators, rather than the hospital administrator of the facility in which they work. The State must ensure that personnel in these positions do not duplicate activities performed by Medi-Cal field office staff. If these positions are not being used to eliminate the work required of Medi-Cal field office staff, they should not be funded by Medi-Cal.

Response

The Department is in the process of closely examining the relationships and functions of these positions. Interagency agreements (currently being processed) between DHS and the Department of Mental Health, and between DHS and the Department of Developmental Services stipulate that Medi-Cal funded persons in state hospitals must be engaged exclusively in Medi-Cal related activities. These persons follow the directives and are under functional authority of the Medi-Cal Division, although supervisory resonsibility is maintained by the Departments of Mental Health and Developmental Services, respectively. The future contract for these positions may be modified based upon the Department's findings.

Medical Review/Independent Professional Review

A. Recommendation

The State needs to ensure that the social needs of long-term care residents are being met. Each field office should be adequately staffed so that a social services consultant can be part of the team during the on-site medical review process. The nursing and social assessments should be integrated to meet the intent of the regulations regarding an annual medical review by an interdisciplinary team.

Response

The State recognizes the social needs of long-term care and mental hospital patients. It has placed one of the highest priorities on filling the social services consultant positions that are vacant. It has also hired social services consultant staff on an emergency basis until a permanent resolution can be accomplished.

B. Recommendation

The State should improve communications between Licensing and Certification and the field office medical review teams. If follow-up is the responsibility of Licensing and Certification, the medical review teams should be kept informed of actions taken to correct problem areas.

Response

This procedure is carried out by an exchange of reports on facilities and the use of a referral form to annotate the request for follow-up. This will be a subject of a section of the monthly administrators meeting to urge documentation of closure on this system. (See attached 1974 MC 168.)

It is done on an informal system since Licensing and Certification sections are generally housed either in the same or nearby locations.

Prior Authorization

A. Recommendation

In order to eliminate duplication, the State should direct the fiscal intermediary to discontinue the process of reviewing the Medi-Cal and Professional Standards Review Organization (PSRO) approved claims for medical necessity and length of stay. The State should negotiate a written change in the present fiscal intermediary contract and eliminate such review requirements in the new fiscal intermediary contract, if applicable.

Response

The Department maintains all edits and audits for inpatient claims in order to review the claim for inconsistencies between the information on the claim, the TAR, and previous history. In working with CSC to implement inpatient claims processing, the appropriateness of all edits and audits (including medical necessity and length of stay) will be reviewed and approved by the Department, before CSC inpatient claims processing begins.

B. Recommendation

DHS should quickly negotiate Memorandums of Understanding (MOUs) with the remaining 14 conditional PSROs and the other 5 PSROs when they attain conditional status.

Response

The preponderance of evidence currently indicates that there is a significant degree of uncertainty about the PSRO program's ability to be an effective partner in health care cost containment efforts. Therefore, DHS will continue prudently to implement the PSRO concept while trying to minimize the fiscal risk to California taxpayers. Our concern is to provide medically necessary services without switching from more effective to less effective methods of utilization control.

State of California

Department of Health Services

Memorandum

o : All Field Office Administrators and
Consultants

Date : May 11, 1979

Subject: Documentation of Prolonge
Care Justifications

Telephone: ATSS (916) 485-9166
(916) 445-9166

From : Tom Heerhartz, Chief
Field Services Section

Attached is a prototype 3003 justification form for prolonged ICF/SNF care. I would like to reiterate that all criteria outlined in the May 1975 Operating Procedures SNF/ICF "Prolonged Care" Authorizations must be met, and the 3003 form must be completed prior to authorization of prolonged care. This includes: length and appropriateness of placement, qualifying diagnosis, history, medications, etc.

Prolonged care justification has been scheduled as the subject of the next statewide training session. Effective immediately, however, field administrators have the on-going responsibility for validating that prolonged care criteria are met, including: 1) ensuring that staff have received instructions, and 2) sampling completed 3003 forms and prolonged care TAR's for completeness and correctness.

WH:cs

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH SERVICES
FIELD SERVICES SECTION

MEDICAL REVIEW
(NURSING ASSESSMENT)

E [illegible] Patient SEX ☒ M ☐ F CASE NUMBER [illegible] 00 0 000000000
BIRTHDATE [illegible]/86
ILITY ---------------- PRESENT STATUS: ☐ NH ☐ IC ☐ RC ☐ OTHER
RESS Anywhere, California ATTENDING PHYSICIAN Dr. Hyde
ISSION DATE [illegible]/7/79

GNOSES:

dementia
copd with chronic bronchitis
ASHD
umbilical hernia
decubuti - R. hip
peripheral vascular insufficiency

MEDICATIONS:

1. Folic acid 1 mg. OD
2. DSS 250 mg cap ÷ OD
3. Multi-Vit. tab ÷ OD
4. Digoxin 0.125 mg. OD
5. FESO4 tab ÷ daily
6.
7.
8. Clean R. buttocks & leg with Phisohex &
9. apply neospirin Cr. BID

TE OF LAST PHYSICAL: 1-5-79
ET: Reg/Soft
B WORK Adequate from Acute General to rule out diabetes.

GENERAL CONDITION:

YES	NO	
☐	☒	Bedridden
☒	☐	Confined to Wheelchair
☒	☐	Incontinent - Bladder
☒	☐	Incontinent - Bowels
☐	☒	Agitated
☒	☐	Confused and Wanders in w/c
☐	☐	Noisy
☒	☒	Alert
☒	☐	Cooperative
☐	☒	Ambulatory - Self
☐	☒	Cane
☐	☒	Walker
☐	☒	Self Care

REMARKS: This 93 year old patient recently came to SNF from acute care. Prior to that he had been in another SNF for 3 years.
Good appetite; able to feed self; needs assistance with ADL's; up in wheelchair for brief periods of the day but tires easily and wants to go back to bed. Decubitis care conts. with improvement noted. c/o being hungry continually.
observation: sitting on edge of the bed eating lunch. Neatly groomed. Answered pleasantly but was disoriented ~~[illegible]~~ as to time. Seems to be appropriately placed and will need SNF indefinately.

NEEDS HELP IN:

YES	NO	
☒	☐	Transferring in/out of bed
☐	☒	Feeding
☒	☐	Bathing

NURSING PLAN OF CARE

☒ Adequate ☐ Inadequate

	YES
PROGRESS NOTES WRITTEN ONCE A MONTH?	☒
MEDICATIONS REVIEWED BY PHYSICIAN EVERY 30 DAYS?	☒

TAR INFORMATION:

☒ Correct

DATE OF VISITS: [illegible]

Annual

INTERVIEWER: _______________ R.N.

RECOMMENDATION:

☒ Skilled Nursi
☐ ICF Prolo
☐ RCF

State of California

Department of Health

Memorandum

MANAGEMENT

SNF\ICF

Level of Care

To : John Larrea, Chief
Medi-Cal Services Review
and Control Branch
8-1618

Date : November 23, 1976

Subject : Field Evaluation of the Application of Prolonged Care Criteria

Via : Paul Keller
Assistant Chief
Field Services Section

From : Linda McCready
Field Services Section

My general impression of the offices I reviewed is that the criteria for placing patients on prolonged care appear to lead to appropriate placements, and appear to be used effectively and consistently. I saw only one case where I questioned the appropriateness of the placement , and in that case I am certain that the problem was on of incompleteness of documentation, rather than an error in placement.

In discussing the criteria and their use with the nurses in the field , it became readily apparent that the vast majority of placement decisions are made on the basis of a combination of the experience and knowledge of the nurses, with a large element of "gut feeling". This should not be taken to mean that there is no justification for the decisions. On the contrary, the objective evidence of the files substantiates the subjective judgements of the nurses. The patients we carry on prolonged care status are old, they have multiple medical conditions requiring long term care, and they have been in their current level of care (and usually in the same facility) for long periods. Following is a summary of the data gathered from a review of 192 files in the four offices I visited. While this in no way constitutes a statistically valid sample, I do not believe that a more carefully selected sample would be significantly different in its overall findings.

A smaller sample of cases not on prolonged care was taken in Sacramento and San Bernardino for comparison. The resulting data are arrayed alongside the prolonged care data on the attached table. These data demonstrate distinct differences in the two groups: the prolonged care patients are older than the regular patients, they have been in the facilities for two to three years longer, and in SNF they have a larger number and variety of qualifying diagnoses (i.e., diagnoses which are listed in the operating procedure as indicating a need for prolonged care.) In ICF, the number of diagnoses is slightly higher for non-prolonged care patients, but because of the small size of the sample, this is inconclusive.

The sample was selected by requiesting that the file clerk in the long-term care unit randomly selected approximately 60-80 SNF files with prolonged care labels, taking [illegible] 1 or 2 files per facility (the files are [illegible] within facilities.)

Approximately 20 ICF files and 20 State hospitals files were similarly selected (the latter in Los Angeles and San Bernardino only.) From the stack of folders in each group, I then selected a smaller sample for review. The clerks were not given any prior warning, and they were asked to deliver the files immediately, in order to lessen the likelihood of any kind of screening of the files.

Once the files were pulled, I reviewed each one against the attached checklist, and checked all diagnoses or conditions which coincided with those listed in the operating procedure for prolonged care authorizations. Where a serious condition existed which was not specifically listed in the procedure, this was noted on page 2 of the checklist (examples: convulsive disorders, mental retardation, senile dementia, etc.)

A summary of the information gathered is below. In addition, I interviewed on or more lead nurses in each office. A summary of their comments and answers also follows.

SAMPLE DATA PROLONGED CARE

	PROLONGED CARE SAMPLE					CONTROL SAMPLE (Patients not in Prolonged Care)		
SNF	Sacramento	San Berdo.	Los Angeles	St. Barb.	Totals	Sacramento	San Berdo.	Total
Average # of months in facility to date	-	40.7	52.1	40.9	44.9	25.9	7.8	16.6
Average age of patient	78.8 yrs	71.1 yrs	79.5 yrs	77.0 yrs	76.8 yrs	70.6	76.7	[illegible]
Average # of diagnoses*	5.8	11.3	7.8	8.4	10.4	4.9	8.8	[illegible]
ICF								
Average $ of months in facility to date	-	45.1	54.4	23.0	42.6	26.4	31.7	[illegible]
Average age of patient	83.0 yrs	66.1 yrs	74.1yrs	73.3 yrs	73.3 yrs	73.3	61.1	[illegible]
Average # of diagnoses*	4.9	4.1	4.3	6.9	4.8	4.7	6.7	[illegible]
State Hospitals								
Average # of months in facility to date	-	56.4	145.5	-	115.8			
Average age of patient	-	35.4 yrs	24.0 yrs	-	27.8 yrs		No data collected	
Average # of diagnoses*	-	7.2	9.7	-	8.9			
Sample Size								
SNF	27	27	38	40	132	29	30	59
ICF	11	16	10	8	45	10	10	20
State Hospitals	-	5	10	-	15	-	-	-

*Refers tb diagnoses listed in the operating procedure as indicating need for PC

QUESTIONS AND COMMENTS

What percent of your total patients now are in prolonged care status? Sacramento - 54%, San Bernardino - 74%, Los Angeles - 55%, Santa Barbara - 80%.

Do you ever assign patients to prolonged care at the time of admission? All offices replied no. This was supported by review of the files. As the above data show, the average patient in SNF had been in the facility for 44.9 months at the time of this survey. PC has been around for only a little over one year, meaning that most SNF/PC patients had been in facilities about three years before PC began.

Do you ever assign patients to prolonged care without an onsite review? Three of the offices said never; this was borne out by review of files. Mary Johnson from Los Angeles said that occasionally a very old, very incapacitated patient might be assigned to PC without a review, but only where the facility had a good record of appropriate placements.

Do you screen routine TARs for potential PC patients and schedule onsites where appropriate: Three offices said they do, and they identify many PC patients this way. Los Angeles: Kirt Samuels said he did not have sufficient time and staff to screen; could just barely keep up with the current workload as it is. Mary Johnson said she screens for PC in her unit, and does schedule onsites on basis of routine TARs.

What about a patient who is obviously terminal or total care at admission - a cancer or accident victim who just isn't going to get better? All offices report that they authorize 2 months on the admission, and schedule an onsite as soon as reasonable. Even in these cases, PC is not approved at admission without an onsite.

How do you handle cases where a patient on prolonged care goes into acute, then returns to the facility? Do you give a two month authorization or return the patient to prolonged care immediately? Los Angeles authorizes two months, then returns the patient to PC on the next reauthorization. Santa Barbara evaluates each case individually before making a decision. Sacramento and San Bernardino return patient to PC immediately unless there is some obvious reason for not doing so.

How were you trained/oriented to the application of the PC criteria? All offices had some or all of their staff present at the training given at the El Rancho last year. New staff have generally been given on-the-job rather than more formal training in this area. Lack of time for formal training was given as the reason.

Do you/how do you monitor the performance of the nurses you supervise with regard to authorization of prolonged care? Do you periodically review a sample of their decisions, for example? Sacramento - Joan Paterson monitors informally in the course of reviewing TARs. The same is true of Mary Johnson in Los Angeles, and Robby Dwyer in Santa Barbara. Robby also reports that the three nurses in her office conduct many informal discussions of cases, and she is familiar with most of their patients. Kirt Samuels does not monitor this process, again because of the pressures of time. Vern Davis, in San Bernardino, reviews all 3003s, as well as a sample of the TAPs.

Do you have any questions about or problems with the PC criteria? All offices responded no.

In summary, then, I believe that the prolonged care criteria serve the purpose for which they were developed, and that the high percentage field offices sampled are making appropriate placements. It seems desireable to me that those offices which are not monitoring their performance should do so periodically. Also, I would find it interesting to see some demographic information on the patient mix in each office since this may well be the main factor in the difference in the portion of the population which is on prolonged care in each office. I discussed that situation with each lead nurse, and they all commented that Santa Barbara and San Bernardino had large populations of retired and elderly people, while Sacramento and Los Angeles have a more heterogeneous population. I was unable, in the time available, to document this.

In the absence of demographic data, it is probable that additional prolonged care placements can be effected through an aggressive approach to reviewing existing "non-prolonged care" cases. One approach to this is through follow-up instruction to the lead R.N.s in the "low" offices, with emphasis on the long-range effect of near-term efforts to identify potential Prolonged Care patients. One way to handle this training would be to have a lead nurse from a "high" office assist other offices in evaluating such cases. Since all but one of the "low" offices (under 70 percent P.C.) are in Northern and Central California, it would be appropriate to use a northern nurse for this task. Ruth Crumal would be a good choice, especially since Fresno is a "high" office. Because of the workload in Los Angeles, it probably would be better to use a local nurse to assist that office. San Bernardino is a "high" office and has ten nurses. Therefore, I recommend using Vern Davis to assist Los Angeles. Because of the sensitive nature of this sort of "peer review" I feel it is essential that we use lead nurses rather than calling on the line people.

It also seems prudent to get together with the reviewers prior to sending them into other offices to brief them on the situation.

A list of the "low" offices, in priority order, follows.

Priority	Office	% SNF P.C.	%ICF P.C.
1	Los Angeles	53%	46%
2	Sacramento	54%	34%
3	Santa Rosa	60%	43%
4	San Jose	62%	52%
5	[illegible]	[illegible]	74%
6	[illegible]	[illegible]	[illegible]
7	San Francisco	67%	75%
8	Redding	68%	54%

State of California

Department of Health

Memorandum

To : Department of Health
Field Services Headquarters
714 P Street
Sacramento, California 95814

Date :

Subject : Request for Consultative
Service

From : Medical Review Team

______________________ Medi-Cal Field Office

______________________ Originator

By copy of this memo, a request is hereby made of Services Approval Section to provide the listed consultative service(s) to:

______________________________ , ______________________________
(NAME OF FACILITY) (ADDRESS)

Contact Person: ______________________________ ______________________
(NAME) (TELEPHONE NUMBER)

____
(TITLE)

Type(s) of Consultant and Service Requested

Consultant	Service
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________

Comments: ____

____

____

____

cc: John B. Kelly, Chief
Services Approval Section

MC 168 (4/74)

General Comments

III. Fraud and Abuse Detection and Prevention

2. Medi-Cal Management Information System-Surveillance and Utilization Review Section (MMIS-SURS)

Page 13, Paragraph 1

This paragraph states the only reports being used to identify abuse are the drug report (DUR 135) and the PGN report (UM 80/81). The SURS uses many reports to identify abuse, including: DURU 130 and 135, UM 80/81, UM 155 and 156, and others. Under the CSC advanced SUR subsystem, abuse identification capabilities will be greatly enhanced providing the proposed staff augumented is approved.

Page 13, Paragraph 2

This paragraph implies that referrals involving quality of care are automatically sent to the Board of Medical Quality Assurance (BMQA) as that is its jurisdiction. This is not automatically done, as sometimes a review is completed before a referral is made to BMQA, and on several occasions, DHS filed accusations jointly with BMQA, resulting in combined administrative hearings. SURS's first suspension involved a physician providing substandard care.

Page 13, Paragraph 3

In addition to the SURS analyst mentioned, input is also received from the registered nurse and physician members of the review team. Each team member can make an equally valid recommendation on which reports will be audited from MIO.

Page 14, Priority 4

The decision is incorrect; it should read "case is pending and cannot be pursued at this time".

Page 14, Paragraph 2

The report commits the fact that a registered nurse is also a member of the SURS team. In addition, although the medical specialist is usually a physician, there is also expertise available for specialized reviews (optometrist, pharmacists, podiatrist, or a bioanalyst).

Page 15, Paragraph 4 (Recovery)

Extrapolation from the statistical sample to total services is essentially limited to pharmacists. Recoupment resulting from on-site reviews for other services is almost always based on specifically identified data. The utilization of stratified random sampling in other instances does not appear to be sufficiently reliable to allow for extrapolation.

Response to Specific Recommendations

III. Fraud and Abuse Detection and Prevention

A. Claims Processing

2. MMIS-SURS

Recommendation

a. It appears that any reduction of staff would adversely affect the number of cases the unit is able to investigate. Efforts to retain current staffing allocations should be initiated in order to assure adequate emphasis on overutilization of services as well as misutilization.

Response

Concur.

Recommendation

b. While SURS has been very successful in identifying cases for review, better use could be made of the SUR subsystem of MMIS. SURS should continue to work with CSC (new fiscal intermediary) to perfect the reports generated by the SUR subsystem. Improved exception reports should increase the productivity of the SURS staff by providing more accurate and productive data for analysis. Reports such as the attached "Cost Avoidance from SPEAR" (exhibit No. 9C) should be automated by CSC and provided to SURS promptly at the end of each fiscal year.

Response

Concur.

Recommendation

c. Records obtained from providers should be maintained by the State for not less than one year in order to ensure their availability in cases of provider grievances or complaints. Maintenance of this data will assist HEW to assure the correctness and verification of SURS reports. (See 1902 (a) (6) of the State Plans for Medical Assistance.)

Response

State regulations give providers 30 days to appeal a decision. If an appeal is made, records are maintained until the appeal process is concluded. We have attached for your information a copy of SURS Operating Instructional Letter (SOIL) No. 78-27 -- SUR Record Retention/Destruction Procedures.

Recommendation

d. Both in reviewing SURS's own reports and in participating in special HEW projects, it is noted that a heavier workload (cases received) is borne by the Los Angeles Regional Office. SURS should review the staffing between its field offices to assure an equitable emphasis on provider abuse throughout the State.

Response

This review will be made in conjunction with filling anticipated new positions.

B. Nonclaims Processing

2. Explanation of Benefits (EOB) Verification

b. Recommendations

(1) DHS should reevaluate the language on the Beneficiary Explanation of Medi-Cal Benefits (BEOMB) so that recipients can better understand what is expected of them and more readily identify those services printed on the BEOMB.

(2) DHS should examine ways to make it easier for the beneficiary to return the BEOMB as a reporting mechanism. For example, enclosing a preaddressed envelope or having the return address preprinted on the BEOMB.

Response

Such a project has been proposed and is being considered.

Recommendation

(3) DHS should consider whether the sampling system could be programmed to screen out deceased recipients and sensitive services before the two percent sample is selected. This would increase the actual number of BEOMBs mailed for verification of Medicaid services.

Response

Sensitive services are screened out. If one of the purposes of the BEOMBs is to detect fraud, screening out deceased recipients would be counterproductive.

Recommendation

(4) DHS should reevaluate the screening process of those BEOMB responses which are received in order that more appropriate responses are forwarded to SURS and to the Investigation Section.

Response

Our evaluation indicates a (negative) cost/benefit ratio of about $100/$1. Further screening would increase the cost without additional deterrence or recoupment.

V. Investigations

B. Medi-Cal Fraud Unit

Recommendation

DHS should review and, if necessary, revise existing procedures and MOU with the Fraud Control Unit to ensure that all referrals to the Fraud Control Unit meet mutually acceptable minimum standards.

Response

We would concur after we have had the benefit of 12 months of experience.

VIII. Factoring

Recommendation

The state agency should develop procedures, to be implemented by its new fiscal intermediary, to detect the existence of factoring among Medi-Cal providers.

Response

Concur.

ate of California — Department of Health Services

Memorandum

o : Evelio Ruiz
LA-SURS

John Kelly
SF-SURS

Date : March 13, 1979

Subject : SURS Operating Instructional Letter (SOIL) No. 78-27; SUR Record Retention/Destruction Procedures

Telephone: ATSS ( )
( )

om : Audits and Investigations Division
8/1601 2-8444

Effective immediately, the following procedures are to be implemented for the control of record retention and destruction of records.

Procedure

1. Provider and Beneficiary Review Records:

Type of Record	Retention	Method of Destruction
Review Report (Includes all documents concerned with the review: i.e., correspondence, workpapers, etc.)	4 years from the date of Report of Findings Letter.	Shred (1) (2) & (3)
Paid Claims Printouts	90 days after issuance of Report of Findings. Photocopy pages referred to in review report if appealed and make them part of the audit package. Shred unneeded printouts.	Shred
Patient Profiles (used)	90 days after letter of findings.	Shred
Patient Profiles (not used)	Shred after review.	Shred
Medical Records	Same as patient profiles except if part of audit report. If in report, make copies or use originals and make part of report package.	Shred

2. Complaints:

   a. Complaints should be researched upon receipt and filed in alphabetical order.

   b. Corner color codes could be used to denote the month of processing.

   c. Each month the file should be purged and records shredded after one-year retention (suggested retention period).

   d. If a complaint becomes part of a review report, the retention for the document is extended to four years.

   e. Complaint Log -- Shred logs each month after one-year retention.

3. Other Files:

   The Department has established guidelines for minimum retention periods for general files. The retention periods are guides and can be extended if the unit finds it necessary, eg , chron files -- suggested one year. Department guidelines are attached.

Footnotes

1. Contacts for shredding:

Los Angeles Office	Regional Operations	213-640-2900 Jim Walkley
San Francisco Office	Consolidated Fibers	(Through Field Services)
Sacramento Office	Sayer-Frazer	916-929-1219

2. A state employee should be present when the shredding is accomplished, per Department of Health Services Paperwork Management.

3. If the review is appealed, the retention period is extended to three years after final resolution of all disputed items and the issuance of a final Letter of Findings (PL 95-142 -- as spelled out by the Department of Health, Education, and Welfare).

4. Review Reports should be transferred to archives after retention in the office for two years. Keep accurate records as to the location of each of the reports as they could be needed during the two-year storage period. Archives will destroy the records at the end of the retention period.

Paul Keller, Chief
Surveillance and Utilization
Review Section

Attachment

BASIC DISPOSITION SC' 'ULE FOR ENCYCLOPEDIC SUBJECT FILE

ECORDS DISPOSITION SCHEDULE
O. 73 (REV. 1/74)

EE INSTRUCTIONS ON REVERSE AND IN SAM 1646-1646.7

DEPARTMENT (1) HEALTH	SCHEDULE NUMBER (2)	DATE (3)
ORGANIZATIONAL UNIT	PAGE 1 OF 5 PAGES (4)	
ADDRESS (NUMBER, STREET, CITY)	DEPARTMENT OF GENERAL SERVICES APPROVAL NUMBER (5)	

ITEM NUMBER (6)	RANGE OR CUBIC FEET (7)	TITLE AND DESCRIPTION OF RECORDS (8)	RETENTION (NUMBER OF YEARS IN ADDITION TO CURRENT YEAR) OFFICE (9)	STORAGE DEPT. (10)	STORAGE SRC (11)	STORAGE TOTAL (12)	EXEMPT (13)	REMARKS (14)
		Activity Reports						
1		Annual	1		0	1		Purgo Annually.
2		Monthly	1		0	1		Purge Annually.
3		Weekly	1		0	1		Purge Annually.
4		Work Plans	1		0	1		Purge Annually.
5		Associations	2		0	2		Purge Annually.
6		Chron. Files	Maximum 1 year					Destroy Annually.
7		Conferences, Committees & Meetings (Includes agendas and minutes)	2		0	2		Purge Annually.
8		Correspondence - General (A-Z)	2		0	2		Purge Annually.
		Equipment and Supplies						
9		Brochures	Active		0	Active		Until updated.
10		Inventory	Active		0	Active		Until updated.
11		Requisitions	Active		0	Active		Destroy when trancaction completed. Purge every six months.

RECORDS DISPOSITION SCHEDULE
STD. 73 (REV. 1/74)

BASIC DISPOSITION SCH LE FOR ENCYCLOPEDIC SUBJECT FILE

SEE INSTRUCTIONS ON REVERSE AND IN SAM 1646-1646.7

DEPARTMENT (1) HEALTH		SCHEDULE NUMBER (2)	DATE (3)
ORGANIZATIONAL UNIT		PAGE 2 OF 5 PAGES (4)	
ADDRESS (NUMBER, STREET, CITY)		DEPARTMENT OF GENERAL SERVICES APPROVAL NUMBER (5)	

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		Financial						
12		Budgets - By Objectives	4		0	4		
		- Other	4		0	4		
13		State Plan	5		5	10		
14		Audits - Federal	2		2	4		
15		State	2		2	4		
16		Other	2		2	4		
		Legal						
17		Bill Analyses	1		0	1		
		Legislation						
18		State or Federal	1		0	1		
19		Litigation	Active		7	Active +7		Statute of Limitations
		Opinions						
20		Attorney General	3		4	7		
21		Department Legal Staff	3		4	7		
22		Regulations	Active		0	Active		Destroy when Regulations printed.

BASIC DISPOSITION SCHEDULE FOR ENCYCLOPEDIC SUBJECT FILE

ORDS DISPOSITION SCHEDULE
. 73 (REV. 1/74)

INSTRUCTIONS ON REVERSE AND IN SAM 1646-1646.7

DEPARTMENT (1) HEALTH
ORGANIZATIONAL UNIT
ADDRESS (NUMBER, STREET, CITY)
SCHEDULE NUMBER (2)
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DEPARTMENT OF GENERAL SERVICES APPROVAL NUMBER (5)

ITEM NUMBER (6)	XANCEX XOBX CUBIC FEET (7)	TITLE AND DESCRIPTION OF RECORDS (8)	RETENTION (NUMBER OF YEARS IN ADDITION TO CURRENT YEAR) OFFICE (9)	STORAGE DEPT. (10)	STORAGE SRC (11)	STORAGE TOTAL (12)	EXEMPT (13)	REMARKS (14)
		Organization						
23		Charts	Active		0	Active		Until updated.
24		Plans	Active		0	Active		Until updated.
		Personnel						
26		Absence Reports	2		0	2		
27		Affirmative Action	2		0	2		
28		Attendance Records	2		0	2		
29		Curricula Vitae	Active		0	Active		
30		Policies and Procedures	Active		0	Active		Until updated.
31		Travel Advances	2		0	2		
32		Travel Vouchers	2		0	2		
33		Policy and Procedures	Active		0	Active		Until updated.

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BASIC DISPOSITION SCHE ..E FOR ENCYCLOPEDIC SUBJECT FILE

ORDS DISPOSITION SCHEDULE
. 73 (REV. 1/74)

INSTRUCTIONS ON REVERSE AND IN SAM 1646-1646.7

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ORGANIZATIONAL UNIT	PAGE 4	OF 5	PAGES (4)
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			OFFICE (9)	STORAGE			EXEMPT (13)	
				DEPT. (10)	SRC (11)	TOTAL (12)		
34		Program Files *						
34A		A. NOTE: It is in this area that variations among Sections will occur. List Program Record Titles Alphabetically. Determine retention periods where possible. Indicate under column 13 by an X whether records must be maintained confidentially and state CAC or other legal authority.						

RECORDS DISPOSITION SCHEDULE
STD. 73 (REV. 1/74)

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		Public Relations						
35		Clippings	2		0	2		
36		Speeches	3		0	3		
		Records Management						
37		Confidentiality	Active		0	Active		Until updated.
38		Disposition Schedules	Active		0	Active		Until updated.
39		Forms (Samples) -	Active		0	Active		Until updated.
40		Printing and Duplication	Active		0	Active		Destroy when transaction complet
41		Holdings and Destruction	1		0	1		Purge annually.
42		Transfer Lists	Active		0	Active		Purge when State Records Center destroys records.
43		Reports and Studies	3		3	6		
44		Statistics	2		3	5		
		Training						
45		In-service	3		0	3		
46		On-site	3		0	3		
47		Sponsored	3		0	3		

tate of California Department of Health Services

lemorandum

: Robert C. James
OB 8/1253

Date : April 25, 1979

Subject : BEOMBS

Telephone: ATSS ( ) 5-4386
( )

rom : Gerald B. Rohlfes
OB 8/827

At your request I obtained the attached estimates from our EDP people.

What these estimates tell me is that we are currently spending about $70,000 a year to produce and mail BEOMBS to beneficiaries. We know their value to us as a fraud detection mechanism lies somewhere between slim and none, because most beneficiaries can't understand them. If we were to spend another $10,000 for the one time expense of programming our computer so that it would describe more explicityly to beneficiaries, the services paid for, we would stand an excellent chance of making the BEOMB system work for the purpose for which it was intended.

I would urge that we do so. To do this, we would need to find some person in the department, knowledgeable in medical terminology, who could translate every procedure code into some descriptive street vernacular of less than 20 characters. I would suggest that we look to the Medi-Cal Benefits Branch or Rates and Fees Section to find this kind of expertise.

Attachment

e of California Department of Health Service

Memorandum

o : Del Luttges, Chief
Data Systems Branch
OB 9/1100

Date : April 10, 1979

Subject : BEOMBS

Telephone: ATSS ( ) 5-4386
( )

From : Gerald B. Rohlfes, Chief GBR
Investigation Section
OB 8/827

Attached are excerpts from a report that was recently published by DHEW Medicaid Bureau on Fraud and Abuse Control in our Medi-Cal program. The gist of this part of the report indicates that our present BEOMB program leaves something to be desired in terms of fulfilling its objective as a fraud detection mechanism. We concur with that conclusion.

To evaluate HEW's recommendations and to consider some other alternatives to improve the effectiveness of the BEOMB program, we need to have some facts that your staff may be able to provide. We need to know:

1. What is the present total annual cost of selecting, preparing and mailing BEOMBS to the approximately 25,000 recipients representing 2% of all beneficiaries who are utilizing benefits each month? (Include all direct costs for EDP machine time, programming, supplies, forms, postage, as well as indirect costs in support thereof, and round to the nearest $10,000.)

2. Is it technically and practically feasible to write an EDP program that could produce from our existing paid claim tape format, a BEOMB with a specific description of all procedures paid for on behalf of a beneficiary in terms that would be understandable to a layman? For example:

Date	Service	Provider	Amt. Paid
March 9, 1979	Routine Phys. Office Visit	H. James, M.D.	$ 8.60
March 10, 1979	Penicillin Tabs #100	Longs Drugs #28	$15.85
March 23, 1979	Chest X-Ray	Franklin Hospital	$42.30

3. If the answer to the above question is yes, how much time and money would it require for our department to make this change? (estimate in total number of months and dollars to the nearest $10,000.)

Can you provide me with some quick answers to these questions? Thank you.

cc: Bob James

te of California

Department of Health Services

emorandum

: Gerald B. Rohlfes, Chief
Investigation Section
OB 8, Room 827

Date : April 23, 1979

Subject : BEOMBS

Telephone: ATSS ( )
( )445-8312

om : Administration Division
OB 9, Room 1100

The present production cost of BEOMBS is approximately $70,000 per year. This figure includes direct and indirect costs. A detailed breakdown is attached.

The computer program that currently produces BEOMBS already has the provision to print the date, description, provider and cost of a medical service in 120 broad categories. The 120 descriptions could be rephrased for well under $10,000 and in about three weeks, provided that the descriptions are pre-defined and supplied to us. Because of printing limitations, descriptions can only be 20 characters in length. One alternative is to allow multiple lines per description. We did not attempt to give you an estimate because the modification would be quite complex.

If the objective were to give a unique description to each procedure code, the changes would be very involved, because of the large number of procedure codes each requiring a different description. This may not be practical, even if technically possible, to implement. Assuming that some kind of compromise could be reached to describe medical services in collective terms, yet to expand the 120 categories somewhat, we estimate the cost for this change to be approximately $10,000. The project could be done in about six weeks.

I hope this answers the inquiries in your April 10, 1979 memo. If you have any more questions, please feel free to contact me or Mike Neff (322-4186).

C. Bel Luttges, Chief
Data Systems Branch

Attachment

cc: Robert C. James
Deputy Director
Audits & Investigations Division

Mike Neff
Systems Support Section

LL:CDL:jg

DOH
APR 24 1979

BEOMBS

APR 23 1979

ATTACHMENT

1. PRESENT PRODUCTION COSTS:

	MONTHLY	ANNUAL
Computer	$1,400	$16,800
Data Guidance	424	5,088
Programming	50	600
Supplies & Forms	500	6,000
Postage	3,750	45,000
TOTAL	$6,124	$73,488

2. MODIFICATION

	HOURS	RATE	COSTS
A. Rephrase Descriptions			
Analysis	20	$ 27.10	$ 540
Programming	80	23.30	$ 1,864
Key Entry	2	12.80	26
Computer	0.1	650.00	65
TOTAL			$ 2,495
B. Include More Descriptions			
Analysis	200	$ 27.10	$ 5,420
Programming	200	23.30	4,660
Key Entry	10	12.80	128
Computer	0.2	650.00	130
TOTAL			$10,338

Section I
Claims Processing

I. Recommendation

The State is aware of the requirement to improve the SUR system reports and has continuously strived to do this. These efforts should continue throughout the remainder of the MIO contract. Under the CSC contract, an advanced SUR capability is being delivered. We recommend that a schedule be developed and that selected MIO provider history files be converted to the new CSC advanced SUR Subsystem. The results from these runs should be used to follow up on provider fraud and abuse which has remained undiscovered in the past. FFP would be available at 75 percent for these SUR historical runs.

Response

It has always been the State's intention to convert a portion of MIO provider history to the CSC format and process these data through the advanced SUR Subsystem. This will be accomplished on an incremental basis as each claim type is processed by CSC. The advanced SUR Subsystem will initially include 14 months of MIO provider history for all providers except drug, which will be expanded to 29 months of MIO history.

II. Recommendation

This finding highlights the problems encountered in assessing the performance of a large state and states having more than one fiscal agent. The volume of claims processed monthly in California (approximately 3.5 million) dictates that at least a .01 percent claims sample be extracted and extrapolated over the universe in order to produce acceptable inferences. Therefore, it is recommended that the DHS Fiscal Intermediary Office perform a follow-up "focus" type review keying on erroneous payment situations already identified by the State Certification Office on-site representatives. The review should determine the ratio of identified overpayment situations and the effectiveness of existing edits and audits. An alternative would be to direct an independent audit after identification of overpayment situations that will remain after the transfer of contractor responsibility. Either method selected should be completed prior to transfer of the claims processing function to the new contractor.

Response

Follow-up reviews focusing on erroneous payment situations are conducted on an ongoing basis. These reviews occur not only as a result of referrals from the certification staff, but as a result of continuous review of the MIO claims processing system by Medi-Cal Procurement Project monitoring and operations staff. Areas of concern are followed up on a priority basis and corrective action taken.

III. Recommendation

The State should direct a study to determine why the return rate at Blue Cross-South is 13 percent higher than Blue Cross-North. Providers found to have contributed most to this return rate should receive special training to correct inappropriate billing practices.

Response

The State has contacted MIO and determined that the 20 percent figure for Blue Cross-South is erroneous. The Blue Cross-South return rate over the last two years has averaged 8.9 percent which makes it only 1.9 percent higher than Blue Cross-North.

IV. Recommendation

The "Error Status Code Project" should be continued and expanded, under both MIO and CSC, to include all types of errors, e.g., provider, data entry, and systems error status codes. Under the current project, the graphs used to display the "Daily Batch Error Report" error status codes are now hand prepared. We recommend that CSC consider automating the preparation of these graphs. Automated graphics would relieve quality control staff from performing this tedious function and allow them to concentrate on the error causes and corrective actions necessary.

Response

The Department recognizes the need to identify all types of claim errors, including provider, data entry, and systems errors. Several regularly produced Management and Administrative Reporting Subsystem (MARS) reports will provide this data in sufficient detail to both understand specific errors and their causes as well as to identify their origin. The following listing summarizes by specific reports the error detection capabilities of the CSC reporting system:

1. The MR-0-11 or Error Distribution Analysis Report: This report will provide a summary of the error and rejection rates being experienced in claims processing activities. The report will indicate the categories of service in which errors are occurring, and increasing, and will indicate the specific errors which are occurring most frequently. Well-refined error codes will provide a reviewer with the originator of specific errors. This error information can then be utilized in provider education, forms design, and training of claims processing personnel.

2. The MR-0-300 or Data Entry Operator Accuracy Report: This report identifies errors made by specific key data entry operators. Total numbers of errors and average number of errors for particular work shifts are identified for review.

3. The MR-0-18 or Error Frequency Analysis Report: This report shows individual providers who are experiencing high error rates on their claims and identifies the nature and frequency of these errors.

4. The MR-0-104 or Detailed Provider Error Report: This report lists providers whose total error rate is above a certain predetermined level, by edits/audits failed.

5. MR-0-105 or Ranked Provider Error Report: This report lists providers with a total failure rate over a predetermined exception level in decreasing error frequency rate.

6. MR-0-133 or Claim Edit/Audit Report: This report shows by specific edit/audit codes the number or error suspends and the corresponding billed amount for the error suspended claims.

It is anticipated that these reports will provide the State and CSC with sufficient information on both provider and CSC errors. Since the State's Request for Proposal was quite specific on the types of reports required, and since these reports appear to meet our informational needs, there appears to be no reason to modify the current design. After the CSC system becomes operational, error data should be assessed and further additions or changes can be considered at that time. The change suggested by HCFA would require a change order to CSC's contract with no proven cost-benefits.

V. Recommendation

The State's TARs system should be reviewed for the purpose of instituting TAR controls to preclude provider TAR approval falsification.

Response

Currently, TARs entering the payment system have a Medi-Cal field office data stamp verifying that it has been reviewed in that office and determined appropriate. The procedure will be improved upon with the new CSC system in that a copy of the TAR will be forwarded from the Medi-Cal field office to CSC for a file match prior to payment.

VI. Recommendation

The State should institute a special task force to examine actual practices now existent with regard to recipient and provider profile deliveries. All individuals within the various agencies should be specifically cleared to receive this information, and this clearance should be reverified for each individual on a regularly scheduled basis. The various agency requests should be coordinated whenever possible. Recipient and provider profiles should never be transferred through routine mailings, but should require special delivery practices.

Response

The State recognizes that the confidentiality of individual provider and beneficiary information should be carefully guarded. Because there are a large number of agencies working toward the end of utilization control and the prevention and detection of fraud and abuse, it is not always practical to apply the most rigid controls over such information. We have found that the techniques now employed to disseminate provider and beneficiary information have been highly successful in getting needed information to the user, while at the same time retaining the controls necessary to protect confidentiality as required. Authorized user agencies are aware of the need to maintain confidentiality and to report any inadequacies in the present system.

VII. Recommendation

Under the CSC fixed-price contract, the contractor has a built-in incentive to keep manual claims examination to the minimum in order to reduce costs, thus ensure profits. For example, the contractor plans to make use of optical scanning techniques and to require providers to do their own diagnostic coding. CSC should be encouraged and supported in its efforts to maximize the use of automatic data processing technology to reduce costs, error rates, and claims processing cycle time.

Response

The Department has every intention of supporting CSC in its effort to maximize the use of the automated claims processing system. Since CSC is at risk, they lean heavily toward the automated approach to claim processing. In the event the Department should adopt a policy which would necessitate additional manual processing by CSC, we would be required to increase our payment to them via the change order process.

VIII. Recommendation

Ideally, a computer program should be developed now to allow for the purging of data fields which are essential to the performance of computer edits and audits. However, the absence of an extract eligibility file to verify eligibility data entering the system presently negates making that recommendation.

With the phase-in of the CSC contract, the State will provide an extract sequential tape eligibility file to CSC for eligibility verification. By 1980, the State will have completed plans for the creation of an on-line eligibility file, accessible to the fiscal intermediary and to the counties for the automated generation of emergency identification cards. Under the CSC contract, the eligibility file should be used as the only source of eligibility verification and as a source for data elements in building recipient history records and in performing edits and audits. Data from the labels on the claim document itself should be used only for an initial eligibility file match. In converting recipient history from the MIO to the CSC file format, a purge of inaccurate data should occur and a study should be initiated to determine if the State can recover funds for over payments caused by incorrect and incomplete personal identification data in MIO recipient history records.

Response

The Department is in general agreement with this recommendation. The requirement was included in the Request for Proposal and CSC will in fact be obtaining essential edit and audit information from a state supplied, contractor maintained, Recipient Eligibility History File.

The generation of county issued Medi-Cal cards, although not affecting eligibility identification, does sometimes create data voids for history edit purposes. However, the State is working to significantly reduce the county card problems as part of the major eligibility redesign process currently under way. Until this system is operational, the State will continue to experience these problems. It should be noted, however, that communication between the counties, and even SSA and the State, has been improving. This improvement is helping to reduce the errors in the data base CSC will be using for its Recipient Eligibility History File.

With regard to the conversion of MIO claim history data, CSC will be utilizing the cross-reference file developed by the State to link MIO's recipient histories. This file currently contains over 750,000 recipients with multiple identification numbers. The cross-reference of this data will give the State a more accurate record of recipient history for payment and reporting purposes. However, the State's contract with CSC does not require CSC to rerun these histories through either edits or audits. It would appear that any recoveries made from this process would not justify the additional expense of reprocessing the 15 months worth of claims or the recovery effort. Any change to the reprocessing of MIO data would require a change order to CSC's contract.

IX. Recommendation

Companion claims which indicate that potential third-party liability exists should be returned to providers with instructions to contact/bill third-party resources. They should provide the fiscal agent a copy of correspondence confirming that the effort has been made and copies of responses from the third-party resource. This correspondence should be attached to the resubmitted claim. The fiscal agent should pay the resubmitted claim and forward a copy of the claim to the State Recovery Unit for follow-up action. This action should be instituted now and should continue under the CSC contract.

Response

The Department disagrees with this recommendation since experience has proven that it is extremely inconvenient for providers to bill other coverage sources first. The providers often experience lengthy delays in receiving responses to these other coverage billings, and coverage often proves to be very limited or nonexistent.

The following Department policy is followed by our current fiscal agent, MIO, and will be continued under the new CSC contract. The provider, in-state or out-of-state, has the option of first billing the recipient's other health insurance coverage or the Medi-Cal program. Because of the reasons stated above, most providers bill Medi-Cal first. There are four exceptions to this option for providers. Currently, providers of service to recipients who are enrolled in (1) Kaiser Health Plan, (2) CHAMPUS, (3) Ross-Loos Health Plan, or (4) Medicare must bill these programs first. An explanation of benefits or a denial from these programs must accompany the Medi-Cal claim. If the documentation is not present, the claim will not be paid. In the nonexception situations where the provider chooses to bill the other coverage first, he must offset the amount collected from the Medi-Cal billed amount.

Detailed claims information is included on the State's paid claim report which is provided to the State Recovery Unit for follow-up action.

X. Recommendation

The state agency should provide a telephone number for the Title XIX emergency contact, and Electronic Data Systems (EDS) should establish a timetable for ensuring that all emergency contact information is accurate and up to date.

Response

The EDS "Disaster Recovery Plan" has been updated as of April 25, 1979, and the Title XIX emergency contact has been identified. EDS will review this information quarterly to ensure that the emergency contact information is current.

XI. Recommendation

DHS should explain how the State assures that Medicaid is not reimbursing a health maintenance organization (HMO) for services paid for by Medicare or another insurance company. Does the HMO submit periodic invoices which detail services rendered?

Response

There are four methods employed by DHS to assure that Medi-Cal is not reimbursing prepaid health plans (PHPs) for services paid for by Medicare or another coverage carrier:

1. Samples of claims paid by MIO are reviewed to evaluate the accuracy of the fiscal intermediary. Included in the samples are claims that contain restricted service labels which are issued to PHP enrollees to cover services within the scope of Medi-Cal benefits but outside the scope of the PHP's benefits (i.e., dental services for Kaiser enrollees). Inappropriate payments would be fiscal intermediary errors.

2. Samples of claims paid by Blue Shield or Blue Cross Medicare for services rendered to PHP enrollees, who are eligible for Medicare coverage, are reviewed to determine whether or not the Medi-Cal crossover portion (the responsibility of each PHP) is being erroneously paid by the Medi-Cal fiscal intermediary. Inappropriate payments would be fiscal intermediary errors.

3. Computer matches of the PHP Master File and paid claims tapes are run routinely to determine whether or not claims for services provided to PHP enrollees are being paid by the Medi-Cal fiscal intermediary. Except for those services which fall outside of the varying scopes of services for PHPs, any "match" is generally an inappropriate payment. Inappropriate payments would be errors of the Department or its county agents, not the fiscal intermediary.

4. The Department requires that each claim paid by the Medi-Cal fiscal intermediary be accompanied by a Department or county issued proof of Medi-Cal eligibility. The majority of PHP enrollees are not issued that type of proof of eligibility. Instead, each PHP issues its enrollees proof of PHP eligibility.

II. The Recovery Section System

B. Assessment of Health Insurance Recovery System

1. Identification of Available Health Insurance

Recommendation

California should provide additional necessary funds, create systems, and provide necessary training to install the improved health insurance detection system at the county level. If the normal budget system does not permit the statewide expanded program, Region IX suggests a system could be installed with "seed money" to get the system started.

Response

California completed a pilot project in three counties in 1978 to determine alternative methods of improving reported amounts of health insurance. The report by Region IX reflects the findings of that pilot study.

California was administratively planning to expand into an improved county reporting program. We considered using something similar to the "seed money" concept suggested in the Region IX report. These plans were set aside with the advent of passage of Proposition 13 and the ensuing staff limitation problems.

DHS's priorities are directed towards assuring transition to a new fiscal intermediary, protecting the public's health, and paying claims that are currently being submitted. The collection of revenues and the utilization of third-party assets is considered important by the Department. However, overall Department resources are not available at this time to expect an improved health insurance collection program.

Resources within the Recovery Section are being directed to installing a casualty insurance collection program. This program is in transition from the fiscal intermediary to State Government. The transition will be completed on September 30. The Recovery Section will not have resources available to enter into a major improvement in county health insurance detection programs in Fiscal Year 1979-80.

2. Staffing of Units Related to Health Collection Activities

Recommendation

DHS should ensure that the Recovery Section is fully staffed and will remain fully staffed in the future. The Department should take the necessary steps to ensure the computer programming support is adequate to meet the needs of the Recovery Section.

Response

The response to this recommendation is consistent with the response to the previous recommendation. The Recovery Section is gaining staff at this point in time. Department management is concerned that positions be filled so that collection standards can be maintained. Staffing for Fiscal Year 1979-80 has not yet been determined by the Legislature. As those decisions are made, Department management will be able to reexamine and reprioritize work within the Recovery Section.

The computer support needs of the Recovery Section are also affected by the previous stated priorities of the Department.

Recommendation

Region IX is concerned that Recovery Section accumulates $500 in overall health care services before a claim is computer generated to an insurance carrier. Region IX recommends that the State determine how much money is not being billed because of the minimum $500 before a claim is submitted to an insurance company. They further recommend that a reasonable estimate of potential dollars lost be developed. Region IX also recommends that if estimated dollar losses are substantial several options should be considered. Among them to require providers to bill insurance companies first, another would be to reduce the carrier billing level to $50 or to where a level of overall cost effectiveness can be demonstrated.

Response

Including Medicare billings, providers offset from their claims to the Medi-Cal program about $800,000,000 in cost avoidance dollars in 1978. This, plus health insurance collections, is about 22 percent of the total budgeted for Medi-Cal.

California moved its computer automated billing to health insurance carriers to $500 minimum. This did not compromise collections to the State of California. It is the opinion of the Recovery Section management staff that very few dollars in federal or state funds are being lost. The shift in billing level helps the State and the insurance industry by significantly reducing the volume of paper being processed. It is important to note that the insurance industry is not mandated by any federal or state law to accept the Department's computer generated forms. Should the insurance industry mandate use of their own forms, expense of billing insurance carriers would become administratively overwhelming.

III. Recoveries from Casualty Cases

D. Findings and Recommendations

Recommendation

Use of diagnosis codes in casualty insurance collection cases should be studied to determine if individual codes result in recovery or simply in a great deal of paper work.

Response

The Department is planning to review the generation of funds from primary diagnostic codes. This type of management analysis was considered in development of management reporting needs. As this information is generated and is found to be reliable, management decisions will be made to improve overall casualty insurance program efficiency.

Section K
Long-Term Care

ICF Facility Beds

Recommendation

3. Medi-Cal should encourage the development of additional ICF beds through discussion of the issues with provider organizations and other groups concerned with long-term care.

Response (ICF Beds)

3. The Department has discussed the development of ICF beds with provider and other groups. While such discussions are useful in fostering an exchange of information and concerns, we doubt that it can do much to encourage the development of more ICF beds. It has been our experience that the reasons new facilities are constructed are not directly related to the position of the Medi-Cal program.

ICF/DD Services

Recommendation

Issues delaying adoption of higher reimbursement levels for ICF/DD services should be resolved and the State's regulations finalized so that programs can begin to function with adequate staffing.

Response

The issues have been resolved and the regulations providing for the higher rates became effective April 1, 1979.

Home Health Agency (HHA) Services

Recommendation

State regulations must be revised so that home health care services (HHCS) are provided to individuals in need of this type of care without being restricted to those who need skilled nursing services.

Response (HHA -- Limitation of Services)

DHS is in the process of eliminating the skilled nursing prerequisite from Title 22, Section 51337. Section 51125, quoted in HEW's finding, defines the services which must be offered by an agency in order to qualify as a Home Health Agency but does not make a need for skilled nursing a prerequisite for receiving HHA services.

Recommendation

1. Medi-Cal central office staff should meet with representatives of HHAs to consider and resolve coverage, reimbursement, and systems issues.

Response (HHA -- Implementation)

The Department has been in contact with several HHAs and professional HHA organizations in connection with several projects. These projects include a proposed transfer of some patients now receiving in-home supportive services to HHA care and the regulation revision of Title 22, Section 51337.

1. The issue of coverage includes medical criteria and utilization control. Discussions with Medi-Cal field office personnel indicate that the many variables present in home situations preclude precise in-depth guidelines for medical criteria. Basically, HHCS authorizations require:

   a. The patient be homebound,

   b. The services be prescribed by a physician,

   c. The cost not exceed alternative methods of care, and

   d. The services be reasonable and medically necessary.

   One visit in a six-month period for evaluation is allowed without prior authorization; all other services must be approved in advance. Review of denied TARs indicates the usual reasons for denial are procedural rather than medical, i.e., there is no indication that the patient is homebound or that the services requested do not correspond with the written treatment plan. An additional problem has been encountered with Medicare/Medi-Cal crossover patients in that TARs cannot be approved until the 100 visits allowable under Medicare are formally exhausted. HHAs have been advised to submit their TARs just prior to the last allowable Medicare visit in order to expedite processing. This information will be published in a Medi-Cal provider bulletin.

2. Instructions for the written treatment plan which accompanies the TAR are found in Title 22, Section 51337.

3. The cost of HHCS is "reasonably cost-related" and the present reimbursement rate was based on an audit of Medicare cost reports. A new cost survey is currently being proposed by Rate Development. It is possible, however, that the HHA rates will receive a percentage increase from the funds allocated for Medi-Cal reimbursement increases if such an increase is found to be justified.

Recommendation

The State should review the availability of HHCS on a statewide basis. If it is found that some counties or population centers are not covered by

HHAs, some mechanism must be worked out to make these services available. Under federal regulations, home health services are not dependent upon the availability of HHAs.

Response

The Department's understanding of federal regulations, specifically 42 CFR 440.70, is that part-time or intermittent skilled nursing services must be available statewide; there is no mandate that all HHCS be available on a statewide basis. A proposed revision to Title 22, California Administrative Code, Section 51337, includes a provision that where there is no HHA in the area, skilled nursing services may be provided by "any provider authorized to render in-home skilled nursing care". Therefore, the services could be provided by alternative providers. Our field offices will work with the attending physician to locate alternative providers where there is no HHA available to deliver skilled nursing services.

Adult Day Health Care Centers (ADHCCs)

General Comments

Page 7, Paragraph 2

This paragraph contains some inaccurate information. It should read:

Reimbursement for the full package of services has been set at $18.46 for the base rate with adders for consultant physician, transportation (if centers must provide its own van and driver), meals (if center must provide its own cook and kitchen), and an adjustment for geographic differences in cost. Maximum payment is $24.00 and includes base rate, all adders, and would be in an area 15 percent or more higher in costs than the state average.

Page 7, Paragraph 3

There is no minimum of 30 or any other number. Each center has its own licensed capacity.

Observations regarding participants better functioning indicate the program is meeting one of its objectives.

Page 7, Paragraph 4

Staffing given here applies only to San Diego centers and not to program regulations or the other centers. San Diego has a unique network organization and generalizations based on their staffing are inappropriate and inaccurate.

Recommendation

1. Medi-Cal should reexamine its policies on the three-day limit for the initial assessment and on payment for assessment. At present, if an

individual is not recommended for acceptance after the initial evaluation, the center is not reimbursed by Medi-Cal for assessment.

Response

Initial assessment rate is five percent higher than regular rate to allow for those turned down. Informal figures showed about three percent denials.

Recommendation

2. Since ADHCC activities are comprised of a mix of medical, health related, social, and recreational services, there should be further assessment of the nature of these centers as additional ADHCCs come into the program.

Response

Recommendation unclear. Our package of services follows SRS-IM-76-3 Information Memo.

Recommendation

3. Since there are no established criteria for medical consultants to use in determining which Medi-Cal recipients should be placed in ADHCCs, criteria should be developed that will assist field office staffs in knowing when to refer individuals to ADHCCs.

Response

There are criteria for Medi-Cal consultants to use (Section 54209). However, Assembly Bill 1611 makes ADHC voluntary so mandatory transfers or referrals cannot be made. Guidelines for voluntary SNF transfers have been tested in San Francisco.

Recommendation

4. Medi-Cal has developed a series of detailed Adult Day Health Care Centers Procedures letters which are sent to ADHCC directors to assist them in obtaining Medi-Cal authorization for ADHCC services and in developing a record system for the centers. Although procedures have been discussed with field office staff, similar materials should go to field offices explaining the ADHCC program.

Response

We agree. This information has been sent to field offices involved.

Section L
Family Planning

I. Family Planning

Recommendation

DHS must, at the earliest possible date, complete the implementation of its proposed or an alternate reporting system to support all claims for family planning expenditures and 90 percent FFP.

Response

In May 1978, the Medicaid Bureau reviewed DHS's initial proposed system. The Department has completed the design phase of the system making some changes to the initial proposal. Currently, the design package is being reviewed by departmental management. Once this review has been completed, the design package, along with a letter requesting 90 percent funding for the design and development of this system, will be sent to HEW for approval. We anticipated that this package will be forwarded by August 1979. Once the Department receives approval of the system design from HEW, we will proceed with the programming and testing phase of the system development.

II. Sterilization

Recommendation

DHS must take whatever steps are necessary to implement those (federal) requirements before claiming FFP for sterilization.

Response

The Department has developed and is in the process of filing emergency regulations to implement the new federal sterilization regulations (42 CFR 441.250-441.259). An anticipated effective date for the new state regulations is July 1, 1979.

In a letter to Secretary Califano, dated February 9, 1979, the Department requested a waiver from the March 8, 1979 effective date to 60 days after the receipt of a sufficient supply of pamphlets and consent forms from HEW. This would allow 30 days for distribution of the material and 30 days for the waiting period. On April 30, 1979, we received an adequate initial supply of English pamphlets and consent forms. This supply allows the Department to begin distribution of the pamphlets with new state regulations effective approximately 60 days later.

Our fiscal intermediary will be notified of the new state regulations and the necessary changes that must be made to the reporting system. These changes will ensure that FFP will be claimed only for sterilizations which meet the requirements outlined in the new state sterilization regulations.

Recommendation

DHS must assure that sterilization of persons between the ages of 18 and 21 are identified and do not receive FFP.

Response

As outlined in our response to item II, the Department will notify the fiscal intermediary of the changes in the Medi-Cal regulations. Among other things, the new regulations prohibit the sterilization of any person under 21 years of age. Once the new Medi-Cal regulations become effective, persons under 21 years of age will not be sterilized under the Medi-Cal program; therefore no FFP will be claimed.

Recommendation

DHS must review its fiscal intermediary operations on a regular basis to assure that all federal requirements (42 CFR 441.250-441.259) on sterilization are being met.

Response

DHS has a monitoring team located at the fiscal intermediary which is responsible for reviewing all types of claims. The team reviews on a recurring basis a sample of sterilization claims to ensure that providers are adhering to current regulations.

Once the new Medi-Cal sterilization regulations are effective, the team will incorporate in their review procedures the requirements of 42 CFR 441.250-441.259 to ensure that all new federal requirements are being met prior to claiming federal match.

III. Abortions

Recommendation

DHS must take whatever action is necessary to separate abortion expenditures from all other medical expenditures.

Response

We are currently working with our fiscal intermediary, MIO, to modify an existing report so that abortions which are eligible for federal matching will be clearly identifiable. The report currently has the capability of distinguishing family planning services from abortion services; however, it does not now separate those abortions which are eligible for federal funds from those which are not. We anticipate that the modified version of this report will be in place by June 30, 1979.

Recommendation (Procedures, Page 7)

DHS must develop and implement procedures to identify and document any federally reimbursable abortion claim.

Response

Since the Hyde Amendment (August 1977), the Department has been estimating septic, missed, and spontaneous abortion expenditures for federal claiming purposes and adjusting the estimates to actual once paid claim data becomes available. We have neither estimated nor claimed for "Hyde Amendment" abortion since February 14, 1978, when estimating for these abortions was acceptable.

As stated in response V, by June 1979, we anticipate having in place a system which will identify abortion which are federally reimbursable. If at a later date the Department decides to claim FFP for "Hyde Amendment" abortions, we will ensure that all necessary and applicable documentation will have been collected prior to claiming any federal match.

Section M
Prepaid Health Plans/Health Maintenance Organizations

I. DHS/DOC (Department of Corporations) Coordination

Recommendation

1. DHS develop uniform subcontract requirements with DOC and a concurrent subcontract review to eliminate the duplicate requirements on the contractors and reduce the processing time in order for the contractors to comply with the execution time requirements in their Medi-Cal contracts.

Response

1. DOC review of subcontracts for PHPs has not presented problems to date. The potential for future problems will be eliminated if legislation currently under consideration by the Assembly Health Committee is adopted (Assembly Bill 1128). While the approach to accomplish the legislative objectives will be debated, the impact should be achieved through legislation this session. This legislation will make licensure as a Health Care Service Plan as the only organizational, structural, and operational requirement imposed by state statute. Thus if the Knox-Keene licensed plan: (1) met DHS needs, (2) presented a satisfactory proposal, and (3) met the determination of HEW that Title XIX requirements were met, a contract could be negotiated. This change should eliminate the opportunity for differing interpretation of basic statutory requirements.

Recommendation

2. DHS convene a working group comprised of DHS, DOC, and representatives from the PHPs/HMOs and develop uniform marketing brochure language that will meet the requirements of both departments.

Response

2. In addition to the proposed legislation, staff of DHS and DOC are working actively to eliminate the potential for conflicting interpretations of requirements. As a result of the HCFA recommendation, DHS will convene an interdepartmental work group with the specific mission of reconciling the various federal and state statutes and regulations. HEW/Public Health Service/Regional Office, Office of HMO, and DOC officials have agreed to support this activity.

Recommendation

3. DHS obtain from DOC its position on the reasonable general and administrative expense levels for each Medi-Cal contractor, or DHS

revise its regulatory reliance on DOC's determination and enforcement of appropriate general and administrative expense levels.

Response

3. While awaiting the legislative changes, DHS is developing an interagency agreement draft to incorporate formally a reliance by DHS on DOC determinations relative to tangible net equity (TNE), working capital ratio (WCR), and administrative expense ratios. Once the draft agreement is prepared, we will share the document with the HCFA regional officials.

Recommendation

4. Coordination to the maximum extent possible of the on-site audits by DHS and DOC in order to reduce the time required of the contractor to meet with auditors and provide documentation.

Response

4. The developing interagency agreement cited above with DOC also addresses the issue of audits. The discussions appear to be leading to a position where DHS will instruct DOC by contract to perform certain audit tests beyond those normally associated with the DOC audit. These instructions will be specific and address such activities as utilization, sample size determination, procedures, and reporting procedures. The actual on-site audit would be performed by DOC. The workpapers and audit findings for the DHS specific portions of the audit would be provided to DHS under the terms of the proposed agreement. DHS would rely on DOC audit of financial matters.

Summary

The combined impact of the proposed legislation and the interagency agreement with DOC will improve the overall program performance. PHP staff time devoted to dealing with state regulation should decrease. These factors working in concert should bring about an increase in the number of plans willing to contract with Medi-Cal.

II. Subcontract Review and Approval

Recommendation

1. DHS should clarify for each contractor the specific subcontracts required and establish dates for execution of these subcontracts.

Response

Through the combined audit process, DHS has identified each required subcontract. The audit findings list the subcontracts which need to be submitted and give a date for submittal (30 days).

Recommendation

2. DHS should ensure expedient processing of subcontracts with Alternative Health Systems Division (AHSD) by better coordination activities of the subcontract reviewer and contract managers.

Response

The subcontract processing has been expedited. Subcontracts are no longer referred to contract managers for review during the approval process except in rare instances when the reviewer has reason to need more data about the plan in order to determine whether or not the subcontract is reasonable.

Recommendation

3. DHS should require as a condition of contract continuation existence of the required subcontracts by a certain date.

Response

DHS is reluctant to make submittal of the outstanding subcontracts a condition of continuation of the contract. Currently, the majority of longstanding subcontracts have been submitted and approved and as plans acquire new providers they are submitting new subcontracts for approval.

The current outstanding subcontracts are those for providers with whom the plans have had a longstanding relationship but the provider refuses to sign a subcontract. An example of this is Children's Hospital in Los Angeles. Children's Hospital is willing to treat Medi-Cal patients and PHP enrollees but refuses to sign a subcontract. The quandary we are faced with is: Do we terminate a health plan which provides the required services in an acceptable manner because a provider refuses to sign a subcontract? Conversely, do we force a PHP to enter into a subcontract with a different and perhaps less desirable provider because the recognized provider in the community refuses to sign a subcontract? We do not believe we should terminate the contract when the provider refuses to sign a contract and has been a satisfactory provider for a number of years. We would appreciate any suggestions that HEW might have to assist us with resolution of this problem.

III. Control Over Duplicate Payments

Recommendation

1. DHS should determine how it will reimburse HEW for any amounts resulting from improper fee-for-service payments made for PHP enrollees.

Response

DHS has determined it will return to HEW any amount of duplicate payment over the allowable administrative error rate. DHS contends that the HEW regulations setting up administrative error quality control recognizes that a small percent of human error is unpreventable. DHS has asked HEW to apply a formula to determine the allowable administrative error rate. DHS is willing to return any FFP above the administrative error rate.

Recommendation

2. A decision should be made by DHS management on which resolution to the eligibility determination problem proposed by its staff will be adopted so that they can proceed as soon as possible with implementation.

Response

This section refers to the PHP Eligibility Modification System (Eligibility Modification) which is currently being designed by DHS. There appears to be a misunderstanding that Eligibility Modification is being designed to prevent duplicate payments.

It is not. The system is being designed to capture PHP enrollees who are reported as eligible by the counties after the computer run that creates PHP eligibility. The difficulty has been that the county report of eligibility must be received about 15 days prior to the month of eligibility to be captured for the PHP system. Eligibility Modification will suppress Medi-Cal cards and caputure these individuals for PHP capitation as they come in after the first computer run.

However, we do agree that this system is important and are proceeding towards implementation. We anticipate implementation for the November 1979 month of eligibility.

IV. Use of Sanction Authority

Recommendation

DHS should define the necessary documentation and related time frames required in order to apply the sanctions allowed for in Section 53350, Title 22.

Response

DHS staff are currently defining sanction procedures. The Department expects to have the sanction procedures completed by July 1979.

V. Combined Audits

Recommendation

1. DHS should improve management audit staff preparation by specifying how each component of the audit will be accomplished and what documentation is required. This is especially needed in the areas of subcontract documentation, utilization date, and determination of administrative influence over medical decisions.

Response

We agree. The Department recognizes the need for further work in strengthening the management protocol. As part of this improvement process, the audit team will have to better understand and prepare for the audit engagement. The areas of subcontract documents and administrative influence will be looked at closely in the coming months so that appropriate corrective action can be taken. As to utilization, we recognize that this area is important. We anticipate completing a separate utilization audit of each plan during the fiscal year. Therefore, we anticipate the utilization steps followed in the management audit will be eliminated.

Recommendation

2. New staff should not be left on their own to conduct portions of the audit unless they have received specific instructions on how to proceed.

Response

We agree. We believe it is necessary for new staff to have sufficient instruction to enhance the overall audit process.

Recommendation

3. Participation of the contract manager in the audit should be avoided in order to assure objectivity.

Response

We agree. The Department is aware that the participation of the contract manager in the audit process minimizes the degree of independence the audit team can have. To correct this situation, the Department has organizationally separated contract managers from the Audits and Investigations Division.

Recommendation

4. Interaction between the management and medical audit staff should be increased to strengthen the findings in several areas, particularly the determination of administrative influence on medical decisions and the handling of quality of care grievances.

Response

We agree. In recent audits we have encouraged more communication and interaction. Every effort will be made to ensure that management and medical staffs interact to the greatest possible extent.

Recommendation

5. The current management guide steps for verification of utilization data should be revised because they cannot be followed. This is due to the incompatibility of the utilization categories listed in the guide with those for which the PHPs/HMOs collect utilization data for their quarterly reports to the State.

Response

As noted in item 1 above, the Department is in the process of initiating a separate audit assignment for the review of utilization data. This will have a favorable effect on ensuring the quality and reliability of data. The combined audit guide will be updated to reflect the changes in this area.

Recommendation

6. Management audit staff should have a thorough understanding of the allowable legal and financial relationships between the contractor and other entities in order to make a determination on the propriety of the subcontractual arrangements and the status of the contractor's compliance with the prohibition against self dealing.

Response

We agree. The Department is aware of the need for the management audit staff to have a thorough understanding of allowable legal and financial relationships between the plan and its affiliates so that a proper determination can be made with respect to the propriety of subcontractual arrangements and inter-entity self dealings. To the best of our knowledge, the management audit staff is knowledgeable of these relationships. However, a greater attempt will be made in the future to ensure that the audit staff is more fully aware of all relationships prior to commencing field work.

Recommendation

7. The following steps of the management audit guide were not done during the audit observed. These steps should either be done uniformly at all audits, eliminated from the guide, or revised to reflect actual process:

   a. Observation of enrollers in field.

   b. Determination that "meaningful" attempts are being made to enroll people in all aid categories.

   c. Determination that staffing composition of the plan reflects affirmative action principles.

   d. Interview with nursing supervisor.

   e. Observation of grievance staff for several hours over several days (observation was minimal on one day).

   f. Review of backup material for sample grievances.

   g. Determination that quality of care grievances are being appropriately identified and referred to medical director.

Response

The items noted by HEW as not being performed during the audit are being reviewed by the Department at this time. In most instances, we find that the audit steps are difficult to perform and have, in most cases, a minimum of benefit to the audit team. As a result, it is our intent to delete, where possible, those steps which are labor-intensive, but fail to yield reasonable benefits, and to increase our audit scope in areas such as grievance, subcontracts, management assessment, etc.

VI. Resolution of State Audit Findings

Recommendation

1. DHS should use recurrence of negative findings as basis for application of sanctions provided for in new state regulations.

Response

1. The Contract Management Section, in conjunction with the Quality Evaluation Branch, is currently identifying, through formal audits and ongoing monitoring activity, those areas in which contracting PHPs continue to perform unsatisfactorily. It is our intent to initiate a concerted effort in providing contractors technical assistance in the resolution of deficiencies prior to the imposition

of formal sanctions. Definitive sanctioning powers were not provided the Department (short of contract termination and/or the suspension of marketing activities) prior to passage of Assembly Bill 1693 and the promulgation of regulations effective August 1978. Subsequent to this (August 1978) date, contractor deficiencies have not, in our estimate, required the imposition of formal sanctions and/or penalties.

We are, at this time, evaluating the scope and duration of negative audit findings, whether or not they are sufficient to impose formal sanctions.

Recommendation

2. DHS should improve the transition of the monitoring of PHP/HMOs from one contract manager to another to ensure that all audit findings are understood and accounted for.

Response

We agree. We are aware of the impact of staff turnover in relation to the continuity of program and contract specific knowledge and ability. Though we have experienced a high turnover rate over the past three years, we have, in each instance, attempted a smooth and comprehensive transition of data between incoming and outgoing personnel. However, our inability to bring new staff into the unit prior to the loss of seasoned personnel has minimized our success in this undertaking.

VII. Staffing

Recommendation

1. AHSD should increase its staff levels in the contract manager and audit areas to ensure adequate monitoring of the assistance to the PHPs/HMOs.

Response

We are attempting to ensure effective management of the entire Medi-Cal program within the limits of available resources. Priorities for additional staff will be based on program impact within the broader organization.

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